UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

IN RE: NEW ENGLAND COMPOUNDING PHARMACY, INC. PRODUCTS LIABILITY LITIGATION MDL No. 2419

Master Dkt: 1:13-md-02419-RWZ

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THIS DOCUMENT RELATES TO:

All Actions

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VIDEOTAPED DEPOSITION OF
JOHN W. CULCLASURE, M.D.

9:05 a.m.
March 23, 2015

Suite 1100
315 Deaderick Street
Nashville, Tennessee

Blanche J. Dugas, RPR, CCR No. B-2290

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Melissa Howard, paralegal

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Videotaped Deposition of John W. Culclasure, M.D.
March 23, 2015

VIDEOGRAPHER: Here begins Tape No. 1 to the videotaped deposition of John W. Culclasure, M.D., taken in the matter of New England Compounding Pharmacy, Inc. Products Liability Litigation. This deposition is being held at 315 Deaderick Street, Nashville, Tennessee 37238, on March 23 of 2015. The time is 9:05 a.m. My name is Daniel Makowski and I'm the video technician. The reporter today is B.J. Dugas. Would counsel please introduce yourselves for the record and state whom you represent. Then the court reporter will swear in the witness.

MR. KINNARD: I'm Randy Kinnard and I represent the PSC.

MR. CLAYTON: Daniel Clayton, on behalf of the PSC.

MR. NOLAN: George Nolan for the plaintiffs.

MR. REHNQUIST: Jim Rehnquist, UniFirst.

MR. LEADER: Bill Leader, for

plaintiffs.

MR. SCHRAMEK: Adam Schramek, Saint Thomas entities.

MR. DREW: Nicholas Drew, UniFirst.

MR. GASTEL: Ben Gastel, plaintiffs.

MR. STRANCH: Gerard Stranch, plaintiffs.

MS. CARRICK: Megan Carrick, Dr. Lister and Speciality Surgery Center.

MS. HOLLABAUGH: Lela Hollabaugh, Saint Thomas Hospital, Saint Thomas Health, Saint Thomas Network.

MR. TARDIO: Chris Tardio, for the Tennessee clinic defendants.

MR. CLINE: Matt Cline, for the Tennessee clinic defendants.

MR. GIDEON: C.J. Gideon, for the witness and Howell Allen Clinic, as well as St. Thomas Outpatient Neurosurgery Center.

JOHN W. CULCLASURE, M.D., having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. KINNARD:

Q. Sir, would you tell us your name, please.

A. John Culclasure.
Q. Dr. Culclasure -- is that how you say it?
A. Culclasure, yes.
Q. Doctor, I haven't met you yet. My name is Randy Kinnard. And you've just took an oath. You understand that?
A. Yes.
Q. You've testified before, haven't you?
A. Yes.
Q. And you understand that the oath you just took is as important as the one you could take in court?
A. Yes.
Q. If anyone including myself asks you a question today that you don't understand, will you ask for clarification?
A. I will.
Q. I don't want to talk over you when you give an answer. And try to let me finish a question. Okay?
A. (Witness nods head affirmatively.)
Q. And try to say "yes" or "no" when an appropriate yes or no is the answer. Okay?
A. I will.
Q. During the deposition, if you realize

you've made a mistake, will you agree to try to fix it during the deposition?
A. Yes.
Q. We're going to take breaks. I'm going to shoot for about every 50 minutes. If you need one before that, you're welcome to take it. Okay?
A. Yes.
Q. How many patients of St. Thomas Outpatient neurological --
MR. GIDEON: Neurosurgical.
Q. (By Mr. Kinnard) -- Neurosurgical Center died from meningitis?
A. 13, I believe.
Q. How many were injured?
A. I think 113 got sick.
Q. Do you agree that this was a catastrophe?
A. Yes.
Q. You understand the importance of your testimony today, don't you?
A. Yes.
Q. Were you the medical director of this center?
A. Yes.
Q. Were you overall in charge of it?
A. I'm -- I don't understand the question.

Q. Of the center. Were you overall in charge of it?
A. Well, there's a manager, a nurse manager, and so she was in charge of the day-to-day operations, and I was -- I'm the medical director.
Q. Did she answer to you as the medical director?
A. For clinical issues, not for -- not for personnel matters or other things along those lines.
Q. Okay.
A. We would collaborate, I guess, if there was an issue like that.
Q. Let's go over your background, Doctor. Where were you born?
A. Orangeburg, South Carolina.
Q. When?
A. 1957, January 23rd.
Q. And where were you raised?
A. About ten miles away in a smaller town. St. Matthews.
Q. Where did you go to high school?
A. In Orangeburg. Wade Hampton Academy.
Q. What year did you graduate from high school?
A. 1975.

Q. Then what did you do?
A. College.
Q. Where did you go?
A. Wofford College.
Q. Where is that?
A. Spartanburg, South Carolina.
Q. Was that a four-year program?
A. Yes.
Q. What kind of degree did you get?
A. A BS in biology.
Q. And when did you graduate?
A. In 1979.
Q. Then what did you do?
A. Went to medical school.
Q. Why did you want to go to medical school?
A. My grandmother's brother was a big influence on me. He was the town doctor. St. Matthews is about 2000 people, then and now. It hasn't really grown. But he -- he went to Wofford. He graduated medical school in the 19 -- around 1914 or '15 or '16, somewhere in that range. And came back and practiced in St. Matthews until -- until his death when he was about 92.
Q. So that man's influence caused you to want to go to medical school?

A. Yes. My grandfather -- my maternal grandfather died before I was born, so he was like a grandfather to me. He encouraged me to go to Wofford.
Q. When you went to medical school, first, did you have a goal to become a particular specialist or not?
A. No. No goal.
Q. And how long was medical school?
A. Four years.
Q. When did you graduate from medical school, Doctor?
A. 1983.
Q. Medical and University of South Carolina?
A. Yes, sir.
Q. Then what did you do?
A. Started my internship in the Army.
Q. Now, what sort of -- did you have an arrangement with the Army of some type?
A. I had an obligation from undergraduate school, from ROTC, an academic scholarship.
Q. So in undergrad, you were in ROTC?
A. Yes.
Q. So they -- the government gave you money, I guess?
A. Yes, tuition.

Q. Now, were you on active duty, and if so, what year were you on active duty?
A. I was not on active duty until starting internship in 1983. Well, I was not considered to be on active duty while I was in medical school.
Q. Now after you finished medical school, did you have in mind a particular specialty?
A. I didn't until -- yes. Once I finished I did, yes.
Q. Okay. What was that speciality you wanted to be in?
A. Anesthesiology.
Q. Why did you want to be in anesthesiology?
A. During our junior year of medical school, we rotate -- we rotated through some of the major specialties -- three months of general surgery, three months of internal medicine, and then two months each of pediatrics, OB/GYN and psychiatry. And at the end of that period of time, I just was still undecided about what I wanted to do. And so I was assisting -- I was at the naval hospital that was just north of Charleston, and I was performing the function that most medical students have done at one time or another, I was holding a retractor. But the way they position the medical students, the students can rarely

see what's going on. So I had one person standing on one side of my arm that was holding the retractor and another on the other side -- on the other side of my arm.
And the way I was positioned, I was facing the anesthesiologist and I couldn't see the field. So I started asking him what he was doing. So that's when I first started thinking about anesthesiology. My two favorite subjects in medical school were physiology and pharmacology. And so each anesthetic is really all about that person's physiology and how they respond to the medications administered. So it seemed like a good -- it piqued my interest at that point.
Q. So you say you began an internship. Where was it?
A. San Antonio, Texas. Fort Sam Houston.
Q. What was the date you began that?
A. July 1, 1983.
Q. Did you complete a year in that internship?
A. Yes.
Q. So does that bring us to July 1 in '84?
A. Yes.
Q. Then what did you do?
A. Started the anesthesiology residency.

Q. Whereabouts?
A. The same place. Brooke Army Medical Center, Fort Sam.
Q. Now, we have a CD. This is Exhibit 133. STOPNC_0400. Would you look at that, please, Doctor. And look through that and tell us if that's accurate, please.
(Exhibit 133 was marked for identification.)
THE WITNESS: The continuing medical education stops in 2012, so that's not updated. But other than that it appears to be accurate.
Q. (By Mr. Kinnard) So you've had some continuing education that's not on this form?
A. Yes.
Q. Other than that, it's accurate?
A. Yes, sir.
Q. Well, look at Page 2, please. And let's look at your -- under -- you state things about your education. Look at 1983 to 1984. This is what you call an anesthesiology categorical internship. Is this what you were talking about a moment ago?
A. The -- yes. The internship that started in July 1, 1983.

Q. Now, looking up above that line, I see 1984 to 1987 an anesthesiology residency program; correct?
A. Yes.
Q. Above that, I see 1988 through 1989, anesthesiology residency program; correct?
A. Yes.
Q. Was this a five-year residency, Doctor?
A. No, sir.
Q. What's missing in there?
A. I worked in the Troop Medical Clinic at Fort Sam in the intervening time.
Q. Now tell me that again. You worked where? In the troop what?
A. It's called the TMC, the Troop Medical Clinic. Had a general practice.
Q. What were the dates of that?
A. Roughly -- let's see -- probably February of '87 until fall of '88.
Q. At least a year and a half?
A. Yes, sir.
Q. Why is that not on your CV?
A. That was not part of my education.
Q. I'm sorry?
A. That wasn't -- that wasn't part of my training or education.

Q. So you stopped your residency in anesthesiology at that point; is that correct?
A. Yes.
Q. Why did you stop?
A. I went to treatment for substance abuse.
Q. Substance abuse?
A. Yes, sir.
Q. What was the substance?
A. Fentanyl.
Q. So during your residency program, you abused fentanyl?
A. Yes, sir.
Q. How? IV, muscular, both, what?
A. Both.
Q. Would you inject yourself in a hospital?
A. I did.
Q. Did you steal drugs to do that?
A. I diverted drugs, yes, sir.
Q. Sir? I'm sorry?
A. Yes. I diverted drugs.
Q. You diverted them. You stole them; correct?
A. Yes, sir.
Q. Why did you start doing that?
A. My ex-wife had a substance abuse problem.

She was going around San Antonio seeing multiple physicians, intending to get medication, and was not able to take care of our children at home because of her pursuit. And so in order to try to wean her off, I initially brought some medication home to try to wean her off so she wouldn't go to the -- all the physicians in town. And that -- I clearly was not able to do that and it just made things worse. And it was just a -- it was -- it was just a very difficult, bad time.

And my -- my -- and in all of that, my -- I -- to relieve stress and get away from what was going on, and trying to manage her and take care of the kids, I tried some of the fentanyl myself, and that's how I started.

Q. When you first tried it, was it IV or intramuscular?
A. Actually, just subcutaneous.
Q. Subcu?
A. Uh-huh (affirmative).
Q. When did you start doing that?
A. Sometime in 1986. I don't remember exactly. Probably that fall.
Q. And there would be times when you were on duty as a resident that you would be under the

influence of fentanyl?
A. Yes, sir.
Q. Looking after patients?
A. Yes, sir.
Q. How long did you use fentanyl like this?
A. Until December of '86.
Q. Then did you get caught using it or what?
A. They -- the staff suspected that something was going on because of mood and personality changes, and so they confronted me.
Q. Somebody challenged you and said, What are you doing?
A. Yes. I think I was called to meet with the program director. And at that point they had arranged for me to go to treatment.
Q. Where did you go to treatment?
A. The residential treatment facility. They called it the RTF at William Beaumont Army Medical Center in El Paso Texas.
Q. How long were you there?
A. Six weeks, I believe. No more than eight. Six to eight weeks.
Q. When you finished that, did you consider yourself clean?
A. Yes, I was at that time.

Q. Then did the Army let you continue your residency program?
A. I went back to Fort Sam and started working at the Troop Medical Center. I resigned my -- I resigned from the residency.
Q. You did resign?
A. (Witness nods head affirmatively.)
Q. Okay. How much of an obligation did you have left for the Army?
A. I think I had a four-year obligation.
Q. So that was not up yet?
A. No.
Q. So you went to the Troop Medical Clinic kind of as a general practitioner?
A. Yes.
Q. How long did you do that?
A. Until I think December of '88, when I went to Walter Reed.
Q. Now, did you have to start your residency over?
A. No, sir.
Q. They gave you credit for what you had done?
A. Yes.
Q. Okay. Then when your duty in this Troop Medical Clinic was over, what did you do?

A. I went to Walter Reed to finish my residency.
Q. And how much more time did that take? I see 1988 to 1989 at Walter Reed Army Medical Center.
A. When I went to treatment, I had I guess seven months left in my residency. So they had me do a full year at Walter Reed. So I started I think December 1st of '88, and finished November 30th of '89.
Q. During this time that you were abusing fentanyl, did you abuse anything else?
A. No, sir.
Q. After you finished your residency at Walter Reed in 1989, what did you do next?
A. I stayed at Walter Reed for about a month on staff, and during that time, I had a decision to make about -- they offered me a promotion and I could stay in or I had the option of getting out. I had been passed over for a promotion three times and so I was scheduled to leave the Army. But the -- my staff guys in the residency program sort of petitioned the promotion board to let -- to reconsider and let me stay in.
And so they did offer me the promotion, but I chose not to take it. I didn't think I could stay

in the Army for a career, and so rather than stay in for four more years, I just -- I opted to get out.
Q. Doctor, there's been a request down at the other end of the table. Could you please speak a little louder. I hear you fine.
A. Okay.
Q. But it's a distance down there.
A. Okay.
Q. What was your rank when you got out of the Army?
A. Captain.
Q. Then what did you do?
A. I took a job in Bowling Green, Kentucky.
Q. What was that job?
A. Anesthesiologist with a group there.
Q. Who were the doctors in that group?
A. Robert Watson, John Villarreal, Ken -- and I'm blanking on his last name now. He retired not too long after I got there. And one other guy from West Virginia who came and left after a few months. I think that's -- I think that's everybody.
Q. What type of work did you do in Bowling Green?
A. General anesthesiology and some pain clinic work, chronic pain, with patients.

Q. When is the first time you ever performed an epidural steroid injection?
A. That would have been during my residency, but I couldn't tell you the year.
Q. Can you approximate the number of epidural steroid injections you personally were responsible for in residency training?
A. I couldn't. It would be just a very rough guess. I don't have a total.
Q. What's your rough guess?
A. I'm sorry, could you repeat the question.
Q. Okay. How many were you personally responsible for in residency training?
A. Of what procedure?
Q. Epidural steroid injections?
A. Steroid. Okay. I didn't know whether you wanted me to include OB epidurals and things like that. To the best of my recollection, I probably spent two months or maybe three in the pain clinic at Brooke Army Medical Center. So while there, I would have done epidural steroid injections. Usually there was just one resident there, so I would have done all of the injections under supervision from the staff guys. It wasn't a high volume. Probably five or six a day for two to three months, because we did other

procedures too.
Q. When you did them in your residency was somebody watching you, or were you allowed to do it alone?
A. Someone was always with us as residents.
Q. Under the supervision of somebody else?
A. Yes.
Q. Is that where you learned to do epidural steroid injections?
A. Yes, sir.
Q. Has your technique over the years changed any, in the way you actually perform the procedure?
A. Yes.
Q. Well, we'll get do that eventually. Did you do some pain management in Bowling Green?
A. Yes.
Q. What percentage of your practice in Bowling Green was pain management?
A. Probably about 20 percent. 15 to 20.
Q. And of that 15 to 20 percent of your practice, what did epidural steroid injections represent?
A. The majority of that 15 to 20 percent. Excuse me.
Q. How long did you work in Bowling Green?

A. A couple of years, I think. I took a job in Washington D.C. at the Washington Hospital Center. My ex-wife had moved from western North Carolina near Asheville to Myrtle Beach. And so that made my drive to see my kids really long and difficult to do on a weekend. And so there was a -- in the early '90s there was an oversupply of anesthesiologists, so I tried to find work in South Carolina closer to them. But the best I could do was D.C. on I-95, so I could at least have a straighter shot to get down there.
So I took a job in D.C.
Q. Back to Bowling Green. Can you estimate for us, please, the approximate number of epidural steroid injections you did?
A. It would be very difficult. I guess on an afternoon -- morning and afternoon, probably 12 to 15 in an afternoon. We'd usually go down in the afternoon after the OR schedule slowed down a little bit. And one of us would have a -- would go down and see patients in the pain clinic.
Q. Was there a clinic devoted to pain management?
A. Yes.
Q. What was it called?
A. You know, I don't think it had a specific

name. It was just in the outpatient department of the hospital, sort of adjacent to the outpatient surgery center. So we just utilized some of the rooms there.
Q. And were they anesthesiologists like you?
A. Yes.
Q. Performing these procedures? All right.
Then who did you go to work for in Washington D.C.?
A. The anesthesia group at Washington Hospital Center.
Q. Were there more doctors there than there were in Bowling Green that you worked with?
A. Yes.
Q. And what kinds of practice did you have there?
A. Just OR anesthesia.
Q. Did you do pain management?
A. No.
Q. Why not?
A. It wasn't an option. That group didn't do pain management.
Q. How long did you work there?
A. Somewhere between four and six months. After I got there, the call schedule was not -- several things -- a couple of things happened. The

people that I met when I interviewed had all decided -- the younger guys that I had met and liked had decided to leave. They had a lot of internal problems within the group.
A couple of the guys were actually just a couple months away from partnership and they chose to leave anyway. And they put me on a call schedule such that I would be on call on Friday one weekend, Saturday the next, Sunday the next, and then a backup weekend somewhere also in that mix -- or after that. So that meant I couldn't drive down to Myrtle Beach to see my kids if I was on call any of those days of the weekend.
So I turned in my resignation because they would not -- I asked them to modify the call schedule for me and they wouldn't. So I resigned, so I -- the people in Bowling Green said if I ever -- if I wanted to come back, I was welcome to do that. So I contacted them and told them I didn't think it was going to work out for me in D.C. and I wanted to come back.
Q. So you went back to Bowling Green?
A. (Witness nods head affirmatively.)
Q. Did you resume the same type practice you described earlier for us?

A. Yes.
Q. Okay. Then how long did you stay there?
A. Until '95.
Q. Then where did you go?
A. I moved to Asheville, North Carolina and started a pain practice there. My kids were with my ex-wife. Then she'd moved back to the mountains and they were living in Hendersonville.
Q. Hendersonville, North Carolina?
A. Yes.
Q. Now, you started a practice there?
A. Yes.
Q. Is that correct?
Now, the practice you left in Bowling Green, you were doing general anesthesia and pain management?
A. Yes.
Q. Now what did you start in North Carolina, in 1995?
A. A full-time pain practice.
Q. Did you do other anesthesia work?
A. No.
Q. Why did you switch to full-time pain management?
A. It was -- the best opportunity for me to be

able to move closer to the kids.
Q. But why didn't you start practicing anesthesiology there also, in like the OR?
A. Well, they had closed -- the medical staff was closed, so I couldn't just go in and offer to do OR anesthesia. I would have had to have been a member of the group -- one of the groups that was at the two hospitals.
Q. How many hospitals were there?
A. Two in Asheville proper. Another one slightly south, between Asheville and Hendersonville.
Q. Now, did you have privileges to admit patients to either of those hospitals?
A. Only St. Joseph's.
Q. You did have privileges there?
A. Yes.
Q. The whole time you were in Asheville, did you run this Carolina Pain Management Center?
A. Yes.
Q. You called it Carolina Pain Management Center; is that correct?
A. Yes.
Q. Did you have other doctors working with you?
A. No.

Q. Well, describe your practice for us, please. How many employees did you have?
A. One nurse who helped me schedule. And then all the administrative things, I had a contract with a management company. They did the billing and taxes and all -- and all of those other things.
Q. Tell us what you did in this pain management.
A. A combination of procedures and medical management of the patients.
Q. Tell us what those were.
A. What -- which were?
Q. Well, the pain management procedures.
A. Procedures.
Q. What did you do?
A. Epidural steroid injections, facet injections, implantable morphine pumps or pain pumps, some spinal cord stimulation.
Q. What percentage of the total pain management that you did was epidural steroid injections?
A. Probably 60 or 70 percent of the procedures.
Q. How many could do you in a day over there?
A. I never booked an entire day, probably

because I would see office visits in the morning or the afternoon. It just sort of -- I think it varied from day to day. And whether I had to go to the hospital to do procedures.
We'd probably do seven or eight in an afternoon. Probably in between some followup visits.
Q. To shorten things up, is it all right with you if I say ESI sometimes for epidural steroid injections?
A. That's fine.
Q. You'll know what I'm talking about; right?
A. Yes, I will.
Q. The way you've described your practice for everybody here, did it stay the same the whole time you were there at Carolina's pain management center?
A. Yes.
Q. It stayed the same. Then when did you stop doing that practice?
A. '98, I believe.
Q. You're welcome to look at your CV.
A. Okay. There we go. Thank you, appreciate it.
Yeah, at that point, I took a -- I had been in solo practice for that time in Asheville and I had not been able to, you know, get busy enough to bring

on another person, another physician. And so I had met some of the people in Johnson City at a meeting, and so we talked about me coming over there. So I visited with them, interviewed, and they offered me a position.

Q. Correct me if I'm wrong. It sounds like you couldn't make enough money at pain management -- excuse me, Carolina's pain management center to keep it going?

A. Oh, I could keep it going, but I couldn't -- to bring on another person, I would need to be able to do, you know, about enough work for one and a half people to then bring on another person, let that new person take over part of -- you know, part of the work. And I was busy, but I couldn't make -- I couldn't get to the point where I could comfortably bring on another person, so...

Q. So you felt uncomfortable having to cover all these things?

A. Right. I was on call all the time. It was very hard to leave town or do anything else, so...

Q. And you'd met these doctors in Johnson City?

A. I don't -- I did go to meet them there, you know, but I'd met them I think at a medical

conference. I think that was our first contact.

Q. And when did you start working with them?

A. I don't remember the -- you know, the month, offhand. But it was in 1998.

Q. Your CV looks like --

A. Oh, there it is. May of '98. Okay.

Q. Started in May of '98 through February '99; correct?

A. Yes.

Q. Well, describe for us, please, the practice of anesthesia and pain consultants in Johnson City when you were there.

A. They covered several hospitals and so -- and Turney Williams, one of the partners in the group, did pain management primarily, some OR anesthesia. And so I worked primarily with him and I did some weekend or night coverage for the -- you know, in the hospital for anesthesia. But primarily spent my days doing pain management.

Q. You did some work in the OR, though?

A. Yes.

Q. As a regular anesthesiologist?

A. Yes.

Q. What percentage of your practice was pain management in Johnson City?

A. 90 or 95 percent.

Q. Were the percentage of your ESIs going up compared to prior practice or staying about the same?

A. I -- I was doing other additional procedures at that time. But I was -- a rough guess probably still 75 percent of the procedures were epidurals.

Q. Why did you leave that practice?

A. I relapsed and went to treatment here in Nashville.

Q. Now what was the problem this time?

A. Same thing.

Q. What?

A. Fentanyl.

Q. What caused you to use fentanyl again?

A. I wasn't -- I wasn't going to meetings and hit some rough spots in the road with my access to my kids and with my ex-wife, and -- and so I relapsed.

Q. What meetings were you not making?

A. AA and NA meetings.

Q. What do those initials stand for?

A. Alcoholics Anonymous and Narcotics Anonymous.

Q. Are those meetings held, you know, for people who were addicted to alcohol and narcotics, in

the same place, or were they different meetings? AA and NA, are they different meetings or the same?

A. Different meetings. They're more AA meetings, so a lot of people who have a substance abuse issue will still go to AA just because there are more options. NA meetings are a bit more limited and -- as far as location and frequency.

Q. Do you remember when you took your first fentanyl drug in this time period?

A. No. It -- let's see. I believe probably December. It was after some issues at Thanksgiving of that year. So probably December.

Q. Of what year?

A. Of 1998.

Q. Again, did you steal drugs from a hospital?

A. Yes.

Q. That was the source of your drugs?

A. Yes.

Q. How long were you abusing fentanyl before something happened that caused you to seek treatment?

A. January of '99. So about a month and a half, I guess.

Q. What happened?

A. One of the nurses who worked in the pain clinic saw me divert some of the medication.

Q. Some nurse saw you take?
A. Yes.
Q. What was it -- what form was it? A syringe or what was it?
A. A syringe.
Q. And where did you put it that she saw you doing this?
A. Most likely in my pocket.
Q. So she turned you in?
A. He did, yes.
Q. Oh, he did. This nurse turned you in. Then what happened?
A. I was -- the Tennessee Medical Foundation, who at that time -- at that time it was headed by Gary Olbrich. And so he came and paid me a visit and the -- the group stopped my clinical duties at that point. And so he recommended that I go to treatment here in Nashville.
Q. So you left that group practice; right?
A. Yes.
Q. And came to Nashville. Where did you go?
A. CPE. The Center for Professional Excellence is what it's called.
Q. Where did you live while you were there?
A. In an apartment. They had -- it was a --

they put us up in apartments in Bellevue.
Q. Is this the campus of this treatment center or not?
A. No, the treatment center itself is near the zoo, would be the best description.
Q. How many months were you in that program?
A. Four.
Q. Did you ever inform any Tennessee board of your being treated over there?
A. Yes. The -- they were -- yes. The board was aware. The TMF communicates with the board.
Q. And when did they find that out?
A. Probably in January. I don't remember. But it's not a -- it wouldn't have been a delayed process. They would have notified them immediately.
Q. Did you inform them or what?
A. I don't remember, but probably the -- it was Dr. Olbrich who informed them.
Q. Did they contact you in January -- anybody with the board?
A. I don't remember. It probably occurred later, once I was in treatment here in Nashville.
Q. Do you remember somebody from the board talking to you?
A. Not in person, but probably by phone. But

I don't -- I don't have a specific memory of that.
Q. You don't have a memory of a phone call either or --
A. I don't remember how the contact was done. It could have been by letter. It could have been a phone call. I just don't remember. And at that point the TMF and Dr. Olbrich were sort of the method of the communication between me and the board at that point, so...
Q. Has your addiction -- excuse me. Do you consider yourself today addicted? Or maybe that's not the right question.
Are you an addictive person?
A. I would say that I'm an addict, but I'm in recovery.
Q. You're a recovering addict. Is that a fair statement?
A. Yes, sir.
Q. Has the fact that you're a recovering addict impacted your practice of medicine and what you do?
A. I chose not to return to the OR where there was, you know, so much access to the medication.
Q. When did you make that decision, that you're not going to work in the OR anymore?

A. During my treatment here at the -- at CPE. And it was just based on the process there, in consultation with the staff there. And that was their recommendation.
Q. Have you relapsed any since then?
A. No, sir. I'm happy to say I have not.
Q. You've what, I'm sorry?
A. I'm happy to say I have not.
Q. Okay. You need a break yet?
A. No, sir.
Q. When you completed your treatment in Nashville, what did you do next?
A. I started a job here in Nashville.
Q. All right. Who was that job with?
A. Neurosurgical Associates.
Q. Who was in that group, please?
A. Ray Hester, Paul McCombs, William Schooley.
Q. I'm sorry, last name?
A. William Schooley.
Q. Stooley.
A. Schooley, S-C-H-O-O-L-E-Y.
Q. Schooley?
A. Doug Mathews, Richard Berkman.
MR. GIDEON: Arendall.
THE WITNESS: Oh, and Rex Arendall.

Thank you.
Q. (By Mr. Kinnard) Arendall?
A. Yes. Rex Arendall.
Q. Anybody else?
A. That's it.
Q. What did that group do?
A. Those are all neurosurgeons. So they do neurosurgery.
Q. Did you know any of these gentlemen before?
A. Yes. I had seen some patients or had some contact with Doug Mathews, and so apparently the group had some internal discussions about adding a pain management physician. So he contacted me while I was still in treatment at CPE.
Q. So when they first talked to you, they did not have a pain management practice; is that fair or not?
A. That's correct. They did not have one.
Q. They wanted to start one?
A. Yes.
Q. And did you start it for them?
A. Yes.
Q. Tell us about that. What was -- what was it like?
A. Well, at first I started seeing patients in

their -- in the main office at Centennial. And it -- and the volume just grew from there, as they got -- as they got comfortable with me and saw what I could do, then we moved over to -- we needed more dedicated space, so we moved over to Doctor's Pavilion. The group had a CT scanner over there. So -- and so we got some space adjacent to the CT scanner area, and started seeing patients there.
Q. What was the clinic called, or whatever it was?
A. It didn't have a separate name. It was just still Neurosurgical Associates.
Q. But there was a site dedicated to pain management. Is that right; yes?
A. A location, yes.
Q. How long did you work with this group?
A. Until they split up in 2005.
Q. When did you start working for them?
A. In '99. July, I believe. Yeah.
Q. I know it varied, it had to have. But give us an estimate, as you moved towards the end of your time with this group, working in the pain management area, about how many ESIs you did a year?
A. Let's say -- I probably did 15 a day plus some other procedures. But let's -- that's probably

conservative. 15 epidurals a day, five days a week, 75 times -- I probably worked 46 weeks a year. So 75 times 46 would probably be a reasonable estimate.
Q. Now, in 2005 something happened to this group. I think you said it split up?
A. Yes.
Q. Tell us about that split.
A. McCombs and Mathews and Arendall joined Neurological Surgeons, and they asked me to come along with them.
Q. So Hester, Schooley and Berkman did something else?
A. Yes, they just remained as Neurosurgical Associates.
Q. And where did you go? What was the name of the new group?
A. Neurological Surgeons.
Q. Who all was in that when you joined?
A. It's the same group I'm with now. It's -- they've just changed the name to Howell Allen Clinic. So Everett Howell, Vaughan Allen, Tim Schoettle, Greg Lanford, Jason Hubbard, Arendall, McCombs and Mathews. Although Arendall and Mathews eventually left for other reasons.
Let's see. Carl Hampf, Scott Standard, and

now Adam Reig and Richard Lebow and Brian O'Shaughnessy. If I missed one, don't tell them.
Q. When you went over there to Neurological Surgeons, did they have a pain management location?
A. Yes. Ben Johnson was doing pain management with them, but it was mostly he ran more of a headache clinic, I believe. It was located at Skyline, but some of the anesthesiologists at St. Thomas Outpatient Neurosurgical Center were doing ESIs there. So when I came over, when we joined the group, at that point they were about to open what's now called Hospital For Specialty Surgery, behind Baptist. And so those three anesthesiologists went over there to provide anesthesia services, and I took over the pain management at St. Thomas Outpatient Neurosurgical Center.
Q. Did it already exist by that name when you went over there?
A. Yes. And if it's okay with you, we'll call it STOPNC.
Q. Yes.
A. Okay.
Q. All right. STOPNC already existed; right?
A. Yes.
Q. Ben Johnson was a doctor?

A. Yes. He still is, yes.
Q. He's not with the group anymore?
A. No.
Q. You took his place?
A. No, we worked together.
Q. Okay. Well tell us about how long you worked together?
A. He left maybe five years ago -- I don't remember exactly when -- and started working with -- I believe it was with Dr. Le, out at Summit. Then he went down to maybe Columbia. I think they asked him to run a pain management center down there.
Q. When did you become the medical director of STOPNC?
A. About the same time that I joined the group. As the other anesthesiologists were leaving and I moved -- and I moved in there to do the pain management stuff, and I became the medical director. Brad Worthington had been the medical director, but since he was no longer going to be over there, they needed someone else to do that, to fill that role.
MR. KINNARD: Well, I think this would be a good time to take a break. I promised every 50 minutes. I might have run a little too long there. So we'll take a few minutes.

VIDEOGRAPHER: This is the end of Tape No. 1 --
MR. GIDEON: We've got a lot of people on the phone, Randy. How long do you want to take this break. Five minutes, seven minutes --
MR. KINNARD: Seven minutes sounds good. Thank you.
VIDEOGRAPHER: This is the end of Tape No. 1. We're off the record and the time is 9:58 a.m.
(A recess was taken.)
VIDEOGRAPHER: Here begins Tape No. 2 in the deposition of John W. Culclasure, M.D. We're back on the record, and the time is 10:09 a.m.
Q. (By Mr. Kinnard) Ready, Doctor?
A. Yes, sir.
Q. Look at the front page of your curriculum vitae again, please.
A. Yes, sir.
Q. I don't know how we managed to do this, but we've skipped something in here. The -- look under pain management, next item to the last. You've got Carolina's Pain Management Center. June '95 through

May '97. Above that is The Pain Management Group, PC in Hermitage, Tennessee. Tell us about that group, please.
A. Yes. And in fact, just as I sat down I looked down at the CV and saw that. I did not go from -- and I hadn't thought about the sequence in a long time, so I apologize. I joined -- from North Carolina I joined The Pain Management Group here in Nashville and worked with -- the doctor's name was Steve Long there. Steve later -- he was difficult to work with. He eventually had his license summarily suspended. He was carrying a weapon with him to work and probably -- and getting some medication -- diverting medication.
So it was a difficult to work with him and so that's actually when I met the folks in Johnson City and took a job there. So...
Q. That -- while working there is when you first met doctors from Johnson City?
A. Yeah, at a meeting, I guess. I don't remember the exact -- that'll be about the only way I would have met them, I think, was at a pain management meeting of some sort.
Q. You're not taking any drugs today, are you?
A. No, sir.

Q. You're not under the influence of anything today except perhaps coffee or water?
A. Both, yes.
Q. All right. So what did you do at The Pain Management Group?
A. Full-time pain management.
Q. Did you go into the OR at all?
A. Only to do stimulator implants or pump implants.
Q. Now look back at Page 2, the second item down, staff anesthesiologist in Hendersonville, North Carolina. Is that information correct there?
A. Yes.
Q. All right. Now, why did you go from Nashville here at The Pain Management Group to Johnson City?
A. Because I found it extremely difficult to work with Dr. Long.
Q. And so there was a work opportunity in Johnson City, is that it?
A. Yes.
Q. And you've told us about that work over there already, haven't you?
A. Yes, sir.
Q. Have we gone over your work history

accurately now?
A. Yes, sir. I believe we have.
Q. Is there anything about your education that we haven't covered?
A. Oh I -- you know, I will just say that when I went back to finish my residency at Walter Reed that they were just -- they were great guys and they supported me and I appreciated that. And they gave me the award for the outstanding resident that year at Walter Reed. So that was part of my education, I guess.
Q. Anything else you want to tell us about your education?
A. I think that covers it.
Q. So now we're up to St. Thomas Outpatient Neurosurgical Center, also known as STOPNC; right?
A. Yes, sir.
Q. In 2011, what percentage of your practice was epidural steroid injections?
A. Generally, at STOPNC, four days a week. On Wednesdays I go to our imaging center. And at the imaging center I do other procedures: Discography, kyphoplasties, spinal cord stimulator trials. So about 80 percent of my time, roughly, would be done -- would be spent doing epidurals when I'm at STOPNC.

Although there are some other procedures I do at STOPNC, but 90 percent or so would be epidurals.
Q. 90 percent?
A. Yes, sir.
Q. Has that increased over the years or always been about the same?
A. I don't -- I'd have to -- I'd have to look at something. I don't know. I don't have those numbers handy. But...
Q. But in 2011, your practice was about 90 percent ESI at STOPNC?
A. At STOPNC, yes, sir.
Q. Of your overall practice, what did ESIs represent?
A. Well, that one day a week I don't do them -- you're asking me to do math on the fly. So I would just guess probably 75 percent, 80.
Q. Was the same thing true about your percentages in 2012?
A. Yes, sir.
Q. And is it the same today?
A. Percentages, yes.
Q. Who owns STOPNC?
A. I believe it's owned equally by Howell Allen Clinic and Saint Thomas Hospital.

Q. What's -- in 2012, what was done in STOPNC for patients?
A. Procedures, epidural steroid injections, facet joint injections, facet joint denervations, some sacroiliac joint injections. That would be -- that would be the -- that would be most of it, 99 percent of it. Occasionally some other unusual -- less common procedure.
Q. This is all pain management?
A. Yes, sir.
Q. If it's pain management, why is it called a neurosurgical center?
A. Well, it was originally used for outpatient surgery that was neurosurgical in nature.
Q. When was that?
A. Up until 2005.
Q. Why didn't the name change after 2005?
A. Sir, I have no idea.
Q. But in 2011 and 2012, St. Thomas Outpatient Neurosurgical Center was a pain management center; is that fair?
A. Yes. Procedure only, no medication management.
Q. Can we call it a pain management clinic? Is that fair or not?

A. That would not be accurate.
Q. Okay. What's the accurate kind of generic description of this center?
A. It's a surgery center; an ambulatory surgery center where pain management procedures are performed.
Q. Is any surgery done in there?
A. No, sir.
Q. Did any surgeons work in there in 2012?
A. No.
Q. You're not a surgeon?
A. No, sir.
Q. Do you know what Tennessee authority regulates this center?
A. The Department of Health, I guess. I think some occupational and safety health people come in too.
Q. Is it licensed as some facility?
A. Yes, sir.
Q. What is it licensed as?
A. As an ambulatory surgery center.
Q. Let's talk about your compensation for a moment. Are you an employee or a member of Howell Allen Clinic?
A. I'm an employee.

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Q. Are you paid a salary?
A. No, sir.
Q. So how do you get paid?
A. I get paid based on what I do, a percentage of that.
Q. Now is that percentage based on some formula, or is it just a set like you get half of whatever you generate or what?
A. It's set.
Q. It's set. All right. What's the percentage you get for whatever you generate for Howell Allen?
A. 60 percent.
Q. Was that the case in 2012?
A. Yes, sir.
Q. Now, in 2012, what were the sources of your income?
A. I don't understand the question.
Q. How did you make money in 2012?
A. By doing the procedure that's we've been discussing.
Q. Did you make money any other way in your life?
A. Oh, I do some expert witness work sometimes. That would be -- that would be my job and

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then sometimes that.
Q. So you've testified as an expert witness before?
A. I was just trying to remember during break. I don't -- I don't -- I may have been deposed. Most of the time I reviewed medical records and worked with the attorney. And you know, things rarely -- I'm not even sure I was ever deposed during that work.
Q. You're not sure what?
A. That I was ever deposed because of the expert witness work that I did. The cases just almost never went to -- they all settled. So I never even got deposed, I don't think. I don't remember being deposed for that.
Q. You have no memory of ever giving a lawyer a deposition as an expert witness before; is that true?
A. I believe so, yeah. I mean, that's true about my memory, but yeah.
Q. Have you ever testified in court before as an expert?
A. Once.
Q. And was it for a medical care provider?
A. I don't understand the question.
Q. Was it on behalf of a medical care provider

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or on behalf of a patient?
A. A patient.
Q. Where was that?
A. Hendersonville, North Carolina.
Q. When was that?
A. Probably '98.
Q. Did you testify that some medical care provider had violated standards of care?
A. Yes, I did.
Q. Do you remember any of the names of the people involved in that case?
A. I do not remember the name of the anesthes -- no. None of the names.
Q. What year did you go to court?
A. I think '98.
Q. And you went in Hendersonville, North Carolina?
A. Yes, sir.
Q. Where were you practicing at the time?
A. At The Pain Management Group.
Q. Where was that located?
A. Out at Summit.
Q. Here in Nashville?
A. Yes, sir.
Q. Do you remember the lawyer who employed

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you?
A. I do not.
Q. What had happened to the patient?
A. She died.
Q. What caused her death?
A. Lack of oxygen to the brain.
Q. All right. And caused that?
A. The anesthesiologist failed to properly intubate her.
Q. Did you testify during that trial that there was a national standard of care pertaining to the provision of anesthesia during that procedure?
A. I don't have a specific memory of my -- of that testimony. I'm sure they probably asked, but I don't have a specific memory of it.
Q. If they asked, would you have had knowledge of a national standard of care?
A. Regarding intubation, yes.
Q. The more ESIs you do, the more money you make; true?
A. Yes.
Q. And ESIs are your bread and butter; true?
A. Yes.
Q. Can we call this STOPNC a center? Is that -- how should we call this in one word? I'm

looking for something like center, clinic, something like that.
A. ASC, ambulatory surgery center.
Q. Okay. It's an ASC. But can you and I call it center and we'll know what we're talking about?
A. Sure I can do that.
Q. All right. In 2012, what days of the week was the center open?
A. I believe Monday, Tuesday, Thursday, Friday. We've had that pattern for a while.
Q. So it was not even open on Wednesday; is that right?
A. Correct. The staff worked ten-hour days on those four days, so they make their 40 hours.
Q. How many weeks where you were open four days a week a year was the center open?
MR. GIDEON: Excuse me, object to the form.
THE WITNESS: Could you --
Q. (By Mr. Kinnard) Okay. Sure. How many weeks per year was the center open?
A. I don't remember if we had to -- if I'm -- at that time I had some people coming in to help, because I couldn't get all of the -- all of the work done. And so if I went out of town they would

generally be able to fill in. But sometimes if they couldn't fill in and I was out of town, then the center would close on those days. So generally it was open four days a week. But there would be times, I believe, that we -- it might have closed because of no physician being available to staff it.
Q. Would the clinic -- excuse me, the center, be closed for Thanksgiving?
A. Yes.
Q. Other holidays it would be closed?
A. Yes.
Q. When ESIs were being done Monday, Tuesday, Thursday, Friday, on average how many were being done a day at the center in 2012?
A. I believe I was probably doing 20 to 22 or '3. And then if there was another physician there, then they would have a similar schedule. I think at that point, we had help two days a week and I was there the other days by myself.
Q. Who would come in to help?
A. Dr. Arney -- Tim Arney, Dr. Steve Dickerson, Dr. Gilberto Carrero, Dr. Rachel Rome.
Q. Would they come in because you physically weren't able to do all the ESIs that were needed?
A. Yes.

Q. If you were able to do all the ESIs on one day, you'd just do them without any help?
A. Yes.
Q. For your involvement with an ESI procedure, how much time of your time does it take?
A. It depends on if it's a -- if it's the patient's first time at the center, or if they're -- you know, if they're coming in for maybe a second or third injection out of a series. The first time takes longer because I'm -- they usually have more questions when I'm talking to them prior to the procedure.
So a new patient, I would review the chart, talk to the patient, explain the procedure, cover the -- go over the risks, and then -- and then do the procedure. At a followup visit it was a bit quicker. Check on how they were doing, how they were responding to the previous injection, counseled them again if they wanted to hear it again, and then do the procedure.
Q. Okay. For a new patient, how much of your total time would be required?
A. Including the procedure time?
Q. Yes.
A. 20 to 30 minutes.
Q. For a followup how much of your total time?

A. 15 to 20.
Q. How long did it take you to perform an ESI?
A. Ten minutes.
Q. Did over 99 percent of the patients who came to this center get there from Howell Allen?
A. Yes, sir.
Q. If efforts to help the patient with pain didn't work through ESI, would that sort of patient get referred back to the doctor at Howell Allen?
A. They would always follow up with their referring surgeon, whether they got better or not.
Q. And would many of these people be operated on?
A. Some certainly would. I don't know the percentage.
Q. They'd get operated on by doctors at the Howell Allen Clinic?
A. Yes, sir.
Q. And where would they be operated on?
A. They could have surgery at any number of locations, from Saint Thomas West to Saint Thomas Midtown, the Hospital For Spine Surgery, Summit -- I mean excuse me, Skyline. The surgeons operated at all of those locations.
Q. Where did they perform most of their

surgical procedures on these sorts of patients when they needed it?
A. Probably the Hospital For Spine Surgery, HHS.
Q. Where is that?
A. Behind Baptist. Behind Saint Thomas Midtown.
Q. And what's that facility called?
A. I think it's now called the Hospital for Speciality Surgery.
Q. Does Saint Thomas have some sort of interest in that facility?
A. Yes, sir, I believe they do.
MR. SCHRAMEK: Objection to form.
Q. (By Mr. Kinnard) What's their interest there?
A. They're part owner.
Q. The state of Tennessee -- I want you to assume this is true -- reflects that in 2011, 548 patients of this center came from Kentucky. What do you know about Kentucky people coming down here?
A. Could you be more specific? I don't understand.
Q. I don't know. I just -- is there some reference, referable service -- excuse me, a referral

clinic or something service in Kentucky that sends patients to Howell Allen in Kentucky?
A. No, sir. Howell Allen's been around for a long time. Dr. Allen and Dr. Howell are well known. Patients come from Alabama as well as -- and Kentucky as well as Tennessee.
Q. Is this center accredited by anybody?
A. Yes.
Q. Who is it accredited by?
A. A Joint Commission.
Q. Does this center, and did it in 2011 and 2012, maintain a policy and procedure manual?
A. Yes, sir.
Q. Is this center a member of the Freestanding Ambulatory Surgery Center Association of Tennessee?
A. I don't know. I don't know if the centers join that or individuals join that organization.
Q. Are you a member of it?
A. No, sir.
Q. Did you have some idea in 2012 how much money you would actually make per ESI?
A. No, sir.
Q. Is it fair that it would be 60 percent of whatever the amount was paid to Howell Allen; is that right?

A. Yes, sir.
Q. Did Howell Allen pay you for the ESIs done at this center?
A. Howell Allen collected the money from the insurance companies and the patients for the work that I did, they retained 40 percent of that to cover my overhead and expenses, and then paid me the remaining 60 percent.
Q. But they would collect money -- Howell Allen would collect money for ESIs done at this center; correct?
A. For the ones that I did, yes.
Q. All right. Did this center pay you some money as medical director?
A. No.
Q. Did the center pay you anything for anything?
A. No, sir.
Q. So the way you got your money for your work over there was through Howell Allen; true?
A. Yes.
Q. You didn't charge the patients personally?
A. No. They got a bill from Howell Allen Clinic.
(Exhibit 122 was marked for

identification.)
Q. (By Mr. Kinnard) Doctor, we've marked as Exhibit 122, diagrams of the floors at St. Thomas neurosurgical clinic and Neurological Surgeons PC. This is also STOPNC Document 0727.
MR. GIDEON: Is this supposed to be a sequential exhibit number? This last one was 133.
MR. CLAYTON: It's not sequential, no. But we have it filled up from 122.
MR. GIDEON: Okay.
Q. (By Mr. Kinnard) This is a three-page document. What we've done is enlarged one floor on Page 35 of this document and on Page 36 enlarged another floor. Do you have the document in front of you, Doctor?
A. Yes, sir.
Q. Let me give you the one that's marked as an exhibit. Page 2 is an enlargement of Neurological Surgeons PC. Are you familiar with this layout?
A. Yes, sir.
Q. What does this represent?
A. That's the office on the 8th floor.
Q. When a patient in 2012 would come to this building for an ESI, would they report to the 8th

floor or not?
A. I don't remember.
Q. What all is done on the 8th floor?
A. Office visits.
Q. For pain management or what?
A. No, generally with the neurosurgeons.
Q. So neurosurgeons work in that clinic?
A. Yes, sir.
Q. On that floor?
Look at the next page, please. Tell us what this is.
A. That's the center.
Q. All right. This is the STOPNC center; right?
A. Yes, sir.
Q. Okay. Would you mark on there where the door is a patient would come through?
A. Probably here. Oh okay, they come in the -- well, they could come in one of two ways. I see the nurses bring them in different ways. So sometimes they'll -- they could come in either. It just depends on the nurses preference, really. They pick them up from the waiting room.
Q. Okay. If you would write "waiting room" on there, that'll help us -- just the word "waiting

room." And then draw an arrow to it.
A. (The witness complies.)
Q. And now draw -- well, write "entrance" to one entrance and "entrance" to another one, and draw an arrow to those.
A. (The witness complies.)
Q. Did you do that?
A. Yes, sir.
Q. Okay. Thank you. I want you to highlight in blue where the patients would wait.
A. You mean the waiting room?
Q. Yes.
A. I'm just going to highlight that side. I mean, I guess those are the -- it's slightly different than this. I don't quite -- that's not quite accurate. But that's the waiting area as it stands.
Q. Obviously, a patient would go in and wait in the waiting area until something would happen; either somebody would come out or a name would be called. What usually would happen?
A. I'm not over there when -- when all that happens. There's a receptionist and she checks them in, and then one of the nurses -- I guess she notifies the nurses at the center, which is just across the hall, and one of the nurses would go and get the

patient, and escort them back into the center.
Q. All right. Then when they escort the patient in, where does the patient go?
A. There are six holding rooms or patient rooms, and they would be placed in one of those.
Q. Is that room where a procedure like an ESI will occur?
A. No, sir.
Q. So there are six rooms that are what -- what do you call them?
A. Well, the -- it's a patients' -- kind of like a holding room. The nurses take their -- complete their nursing history with the patient in that room. I'd go in and talk to the patient while they're in that room, counsel them, answer their questions, mark them. We have to mark them with a marker, based on the procedure that's going to be done. So all of that happens in that -- in those rooms.
Q. Could you outline those rooms in red, please.
A. (The witness complies.)
Q. And off to the side, write something?
A. Patient rooms. How about that?
Q. That's fine.

A. And oftentimes the family member is in there with them, and the family member waits in that room until they come back, usually.
Q. Do you get the patient to sign the informed consent document or does somebody else do that?
A. It could be either.
Q. What percentage of time do you actually get the patient to sign a consent form?
A. Actually, up until late 2014 I did -- I actually witnessed all the consent forms. And then after discussing it with the nurse manager, it wasn't -- it's not really necessary for me to witness it. Anyone can witness the signature. So now it could be me or it could be one of the nurses.
Q. Well, when you would witness the signature, does that mean you saw every patient sign the consent form?
A. Yes.
Q. Now, there are procedure rooms in here, obviously. Will you highlight those in yellow?
A. (The witness complies.)
Q. How many did you highlight, Doctor?
A. Three.
Q. Are ESIs done in all three of those rooms?
A. Yes, sir.

Q. Is that where the majority of the procedures are, in those rooms?
A. 100 percent of the procedures are in those rooms.
Q. Does anything else happen in those rooms? Any other procedures besides ESI?
A. Oh, yes.
Q. Like what?
A. Facet injections, facet denervations, SI joint injections, spinal cord stimulator trials, sometimes pain pump trials. That would be the majority of things.
(Exhibit 123 was marked for identification.)
Q. (By Mr. Kinnard) I'm going to hand you Exhibit 123, which is also PSC Exhibit 31, and ask you to look at that, please. Do you recognize this document?
A. Yes, sir.
Q. What is this?
A. It's part of the consent form. It looks like the first and last pages of the consent form.
Q. Are some pages missing from it?
A. Yes, sir.
Q. What's missing?

A. Two pages.
Q. Now, what's on the other two pages?
A. I couldn't tell you exactly. It's a lot of small type.
Q. Well, you're familiar with the two pages you see here?
A. Yes, sir.
Q. Well, let's go over this first page. First, at the top we see St. Thomas Outpatient Neurosurgical Center; right?
A. Yes, sir.
Q. So is it fair that the first time the patient is seeing this form is at the center?
A. Yes, sir.
Q. Look at the big letters underneath the patient's name: "This paragraph authorizes the surgeon to operate." Is that what it says?
A. Yes, sir.
Q. You're not a surgeon?
A. No, sir.
Q. Paragraph 1, "I hereby authorize and direct John Culclasure, M.D., and associates or assistants of his choice, to perform the following operation." This is not an operation, is it?
A. It's a procedure.

Q. Why don't you use the word procedure instead of operation?
A. The form was created before I started working at the center.
Q. Look at Paragraph 6. "I/We hereby authorize all doctors, pharmacists" -- what is that referring to "pharmacists"?
A. I don't know.
Q. Paragraph 12, what is that about?
A. Could you be more specific?
Q. What's the intent of Paragraph 12?
A. I think if a referring physician has an ownership interest in a facility, that has to be disclosed to the patient.
Q. And this Paragraph 12 has that "I am aware that my physician or his practice does/does not have ownership interest in the St. Thomas Outpatient Neurosurgical Center."
So what's circled here?
A. It would be does.
Q. And that's referring to who?
A. Dr. Shetley, who referred the patient.
Q. Look at the next page, please, Doctor. This is the last page, you say, of the consent form?
A. Yes, sir.

Q. And for some reason we're missing two pages of it. But this is the last page; right?
A. Yes, sir.
Q. There's a place for the patient's signature, time and date, witness to signature. Is that your signature?
A. Yes, sir.
Q. All right. Let's go -- you can put that down, Doctor. Let's go to, say, a new patient coming to the center. Is this the first time you meet this person?
A. If it's a new patient almost always, yes.
Q. If you had met them before it just would have been an accident someplace; you bumped into them or something?
A. No, not necessarily.
Q. You could have had something to do with them?
A. Yes.
Q. But the majority of the time you meet them for the first time in this center; right?
A. Yes.
Q. And you meet them in one of the rooms you highlighted, in the patient room?
A. Yes.

Q. Typically for an average patient who is going to get an ESI, take us through the moment you enter that room to the moment you step back out again. What happens? What do you say and what happens to them?

A. Excuse me. I walk in and introduce myself and then I tell the patient that I need to see their blue wristband, and I make sure that the chart I picked up -- that the name tag on the chart matches their wristband. And so I usually try to -- usually they're nervous, so I try to be a little bit funny and say, Well, I'm glad I got the right patient to do the right procedure." Something like that.

And so then I look at the medical information that's already in the chart about the patient. I look at what the surgeon has ordered for that patient. I review their medical history with them, confirm their allergies, confirm -- find out -- confirm whether or not they're taking a blood thinner and other -- and go over other -- any other coexisting medical problems that they might have. I find out where their pain -- where they're hurting, what other treatment they may have had. And then I explain the procedure to them and then I counsel them. And then I have them sign the consent form, once I've counseled

them. And then I mark their back or neck or wherever the procedure is going to be carried out.

And sometimes they'll ask why I'm writing on them and I tell them so I won't cut off the wrong leg. So again, just trying to make them laugh a little bit, because they're all a little bit nervous about getting an injection. I'm not a good comedian.

Q. I'm just waiting for you to finish your answer. I don't --

A. At that point we're done in the room.

Q. Now, when you first come in that room you told us about, where the patient is, what's the patient dressed like?

A. Street clothes.

Q. I'm sorry?

A. Usually.

Q. Street clothes?

A. Yes, sir.

Q. Okay. Then do they have to change later or what?

A. If we're doing a neck -- a cervical epidural steroid injection or a cervical procedure of some type, then we have them put on a gown. Because I can't prep them and maintain a sterile field if they've got a shirt on. But if it's just their lower

back, we don't make them change into a gown. Once they get on the table they just move their shirt up and their trousers or slacks down and we just prep the area.

Q. When you say you explain the procedure, tell us typically what you tell the patient.

A. Let's see. Well, I go through the sequence that I'm going to follow once they get back to the room. I'll tell them, you know, when you get to the room -- well, let me back up.

I tell them the x-ray person is going to come get them in a few minutes and take them to the room and get them ready. They'll be lying on their stomach on the table and the x-ray person will -- the x-ray person will clean them off with the antiseptic. And I'll come in, I'll look at their back or neck with the x-ray and identify the level for the injection.

At that point, once that's done, I'll numb the skin with a very skinny needle. I tell them they'll feel a bee sting as the numbing medicine goes in. And then I'll tell them after that I'll put the next needle, the epidural needle, through that numb spot, and using the x-ray I will guide the needle into the epidural space or spinal canal.

I'll inject some x-ray dye at that point

when I think I'm in the right place, and the x-ray dye will tell me whether I am indeed in the epidural space or not. If the dye pattern is consistent with the needle tip being in the epidural space, then at that point I'll inject the steroid and take the needle out.

Q. Now, is that your standard procedure, as you do it?

A. That's the description of the procedure and then I counsel -- go over the risks with them.

Q. Okay. Well, what are the risks?

A. Sure. I tell them that the risks include infection, internal bleeding, nerve damage, paralysis, allergic reaction to the medicines used and headache if the needle goes into the spinal fluid sac. And then I ask them if they have any other questions, or if they would like me to elaborate on any of those things I mentioned.

Q. I didn't hear the word "death," Doctor. You don't mention death?

A. That's not -- that would be an exceptional event for an epidural steroid injection and so that's not -- I don't discuss death as part of the counseling process.

Q. And have you told us about everything that happens in there while you're with the patient?

A. I believe I have, yes, sir.
Q. Well, in the deposition, if something occurs to you -- Hey, I left this out -- will you tell us?
A. Yes, sir.
Q. Now, typically, after you leave the room, what happens next, as far as you're concerned?
A. I may have a patient -- excuse me, another patient waiting for their injection in one of the treatment -- one of the procedure rooms. So if that's the case then I would leave that patient and go to the procedure room and perform that injection. If nobody's ready and there's not another patient waiting to be seen, then I would just go sit at my desk or wait outside until the x-ray person picked the patient up.
Q. So if you leave Patient A and there's Patient B in a procedure room waiting for you to come in and do the procedure, you could go there, do the procedure; right?
A. Yes.
Q. And you could go to Patient C, who is on a table waiting for an ESI, that you've already talked to; right?
A. Yes.

Q. And do that procedure?
A. Yes.
Q. And then Patient A could have been taken into a procedure room, and you come in and do the procedure on patient A?
A. Yes.
Q. So the cycle continues while you perform ESIs for that day?
A. Yes.
Q. What time of the day typically does the center open?
A. 7:00 for bringing patients in, I believe, over to the -- to the -- 7:00 for bringing a patient to the patient room.
Q. And what time does your work actually start, normally?
A. 7:30.
Q. And what time does your day normally end, looking after the patients?
A. It varies somewhat, but 4:30 to 5:30.
Q. Doctor, we're going to show you a video now of a lumbar ESI; okay? The first time I show it to you, I don't want to you say anything. I just want to you watch it. It lasts about two minutes. After you've looked at it, we'll play it again and stop it as we need to, to explain.
You ready to do that?
A. Yes, sir.
MR. KINNARD: All right. We'll have to set this up. This is going to take a moment for the people on the telephone.
(Video was played.)
Q. (By Mr. Kinnard) First of all, have you had a chance watch it?
A. Yes, sir.
Q. Is it a fair representation of what it showed -- attempted to show?
A. Yes, sir.
Q. And when you do this procedure yourself, do you do it like that?
A. Yes.
Q. Is this what it's called?
A. Yes.
Q. Let me know, as you look at it the second time, if any of the words are improper or inaccurate.
(Video was played.)
Q. (By Mr. Kinnard) Is all that accurate there, Doctor?
A. Yes, sir.
Q. Is that how you do the needle placement?

A. Not exactly.
Q. How do you do it differently?
A. Well, I would never advance it that much without stopping and checking the x-ray. That was a large -- a pretty long distance to push the needle in without taking a look.
Q. Do you check your location of the needle with fluoroscopy?
A. Yes, sir.
Q. Does the dye enter something like this?
A. Yes, sir.
Q. What is this here, Doctor?
A. It's a cross-section through the lumbar spine.
Q. Now tell us what this is showing, Doctor, as it goes along.
A. At this point the animation is showing the needle being advanced into the intervertebral foramen.
Q. Now what's happening?
A. It's -- the animation is showing the injection of the contrast.
Q. Did you mean the steroid?
A. Could you go back? I thought that was the --
Q. Sure.

A. Just to the end. If you can get to just end, when the blue substance was showing up in the animation.
Q. We'll just have to watch and stop it, because I can't make it go faster.
A. Okay.
Q. This is for the fluoroscopy, correct, that solution, the contrast?
A. Yes, it shows up on fluoro.
Q. Now this is the steroid; correct?
A. Okay, yeah. They titled that "medication administered." Okay. So that would be the steroid, I assume.
Q. Now, this represents the steroid; is that fair?
A. We could -- yes. Because they titled it "medication." The reason I thought it was the contrast was because in the animation, that's the first thing that's being injected after the needle was placed. So that would really normally be the contrast. And the animation and the actual fluoro images don't match. In the fluoro image the contrast is in the ventral epidural space, and in the animation it's in the dorsal epidural space.
Q. Any way else it's not consistent with what

you do?
A. No, not that I'm aware of.
Q. Okay. Well we'll mark this as -- or we had marked it as Exhibit 124?
(Exhibit 124 was marked for identification.)
THE WITNESS: That is only one type of epidural. That's not the one that I used the most often.
Q. (By Mr. Kinnard) What do you use most often?
A. Translaminar.
Q. And what is translaminar?
A. It's the needle placed -- the needle is not directed into the intervertebral foramen. Instead it's inserted between the laminae, which is the bone that forms sort of the -- like a house. It's like the roof over the spinal cord and spinal canal. And there's a ligament that connects one laminae to the -- to the one below. And the epidural space, that's the boundary of the epidural space. And so when the needle passes through that ligament, the tip of the needle is then in the epidural space. And that's really the more common way to do it.
Q. If you would, can you draw us an anatomical

rough sketch of what you're talking about. Why don't you use blue for that and you can use colors as you need to explain.
A. (The witness complies.)
Q. Okay. If you would hold up what you've drawn for the camera and explain what you've drawn. Let him get it focused first, though?
VIDEOGRAPHER: Zoom in?
MR. KINNARD: Yeah, you should zoom in and pick it up.
Q. (By Mr. Kinnard) He's going to zoom in.
A. Okay.
Q. Okay. That's good.
MR. GIDEON: Can you see it, John?
THE WITNESS: Yeah.
Q. (By Mr. Kinnard) Go ahead.
A. If I can get my glasses to focus on the right spot. Okay, this is the skin. The patient's skin. And in this instance the patient would be lying on his or her stomach. And that's the syringe and needle. This is one vertebra, in blue. So that little -- that bone that sticks up is called the spinous process. If you see someone without a shirt on and they bend forward, you will see little bumps under the skin and that bone is what's making that

bump.
This is the vertebral body. That's the bone that is in the front of the spine and it supports our -- the weight of the upper body. And this -- this bone and this bone going out to the side, those are transverse processes. This bone, both of these on each side, that's the laminae. And this bone and that bone that come up, those are pedicles. And what I was -- when I show this to patients, if I'm explaining in a little more detail to them, I just tell them that's kind of like a house, and so they can see, there's the roof and there are the walls and inside that is the spinal fluid sac with the spinal cord inside.
Usually, if I'm showing this to a patient they've asked me something about a previous surgery, and they had a laminectomy and they don't understand what that meant. And so I draw this and I tell them, you know, this is the laminae. So if the surgeon did a laminectomy, he has removed that bone to relieve pressure that's on the -- on the nerves in the spinal cord.
So let me go back to the procedure. This is the needle. It crosses the laminae, and that's why it's called translaminar, because it's crossing the

laminae. Usually when it gets to about -- just before it enters the epidural space, which I've labeled here, the needle engages the ligamentum flavum, or yellow ligament. And at that point, if I'm trying to inject sterile saline through that needle with that syringe, I can't inject, it's because the needle is embedded in the ligamentum flavum. So while maintaining pressure on the plunger of the syringe, I slowly advance the needle forward. And as soon as it passes through that ligament, I can inject -- the syringe will -- it'll, you know, it will let me inject because the resistance is no longer there. The epidural space generally takes -- allows the -- it will accept the liquid easily.

So that is called loss of resistance technique, and that's the technique that's used when we do translaminar epidural steroid injections. Or for that matter, labor epidurals, that's the same technique that's used for that.

So at that point then I would -- to confirm that I really am in the epidural space, I would inject a contrast and look at that with the fluoro. Sometimes there are false losses of resistance. Sometimes you can inject into the ligaments and there may be a plain in that ligament that will -- that

accepts some contrast. And sometimes if you're not all the way in, in the muscle you'll get a loss of resistance. So the contrast pattern helps -- help me confirm that I'm in the epidural space and not in one of the -- you know not outside of the spinal canal. It also tells me if I'm in the spinal fluid sac, because the pattern then is different than when it's in the epidural space. I think that's pretty much everything.

Q. Then you inject the steroid?

A. Correct. Once I've ascertained that the needle tip is in the epidural space.

Q. And does that complete the procedure?

A. Once I remove the needle; yes.

Q. Okay. I need to mark this drawing as Exhibit 134.

(Exhibit 134 was marked for identification.)

Q. (By Mr. Kinnard) Can I have that blue pen back, Doctor. The other one.

A. Uh-huh (affirmative).

Q. Now, the way you performed this procedure as you've explained it, using Exhibit --

A. 134?

Q. -- 134 , is that within nationally

recognized standards of acceptable professional practice for this procedure?

A. Yes, sir.

Q. And is it within nationally recognized standards of acceptable practice for this procedure, regardless of whether it's being done in Nashville, Tennessee, Louisville, Atlanta, or Boston?

A. Is it still the acceptable standard of care?

Q. Yes.

A. Yes.

Q. I'm going to pass you Exhibit 125 now. This is a PSC Exhibit 33.

(Exhibit 125 was marked for identification.)

Q. (By Mr. Kinnard) You recognize this?

A. Yes, sir.

Q. What is it?

A. This is our procedure note form.

Q. How is this note generated?

A. The computer system generates -- or we have a template in it for each procedure and then we modify it with the dose or the level that we did the procedure at.

Q. So what -- somebody has to type in

something -- some information for this to be generated?

A. Yes.

Q. But is it a pretty standard form and this is the way it goes in each procedure?

A. Yes, sir, pretty much, unless we note a deviation or something.

Q. So how does the computer know when things are started? It says, "started," "printed," "anesthesia record"? How does the computer know that?

A. The x-ray person starts it when we -- as we start the procedure. In fact, that made me a bit uncomfortable when I started working there. That's why the third comment that comes up is "Times assigned to the procedure, sequence or an artifact of the software." So it just simply shows the sequence and the times are not necessarily accurate.

Q. So for this procedure 2:52 may not be the time it actually started?

A. It's most likely about the time that it started. I mean you know, start time can vary depending on what's -- what we want to determine is the start time. It could be when I walked into the room. It could be when I numb the patient's skin. So the start time, I mean, is a little bit variable. But

the sequence of events would be accurate. You know, the second one follows the first. The third follows the second. The sixth following the fifth.

Q. Is the time, 2:52 to 3:08 -- is that accurate in terms of how long it takes to do these things?

A. That's pretty accurate. It varies. Sometimes they're more difficult than others. Sometimes they're easier. It just depends on the patient's anatomy.

Q. Now, is the O2 sat monitor already on the patient's finger when you come in the procedure room?

A. Usually, or the patient -- or the x-ray person might be attaching it when I come in. It just depends. They'll call me to try to hurry me up, and so sometimes I might surprise them and get in while they're still putting the blood pressure cup on the patient and the pulse oximeter.

Q. And are the words that are used on this form accurate in describing the procedure from start to end?

A. Let me read through it to be sure.

Yes.

Q. Now look at the second page of this exhibit and tell us why it's in a different format.

A. It's just the way the software prints it out. It's not necessary to have both. The software -- that's just how it does it. It's the same text.

Q. When you do ESIs, do you use some sort of an ESI tray?

A. Yes.

Q. Is it a B-U-S-S-E tray?

A. I don't know.

(Exhibit 126 was marked for identification.)

Q. (By Mr. Kinnard) Let me pass you what we marked as Exhibit 126, PSC Exhibit 41. Have you seen this before?

A. I don't remember. It's not something I would normally see.

Q. Look at the list of things that are in the tray and tell us if these are the same type things you had in your tray.

A. Yes.

Q. Doctor, do you believe that the way you performed ESIs on your patients in 2012 was within recognized and acceptable professional standards for this type procedure?

A. Yes. Excuse me. Yes.

Q. And you're familiar with recognized national acceptable standards of care for this type of procedure, aren't you?

A. Yes.

Q. I want to talk with you now about the center, its responsibilities. You've made statements to other people that this center observes high standards, haven't you?

A. I don't remember a specific conversation, but I would say that we do; yes.

Q. As the medical director, you're familiar with the recognized standards of acceptable professional practice for centers such as this, providing ESI care to patients in 2012, aren't you?

A. Yes, sir.

Q. For short, from now on, can we call that the standard of care for the center? Is that fair?

A. Yes, sir.

Q. And you're also familiar with national recognized standards of acceptable professional practice for a medical director of a center such as this providing services in 2012; is that true?

A. Yes, sir.

Q. And we can call that the medical director standard of care; okay?

A. Yes, sir.

Q. We may call these standards of care "standard," "standard practice" or whatever, but when we use the word "standard," that's what we're going to be talking about; okay?

A. Yes, sir.

Q. Now, in your opinion, did the standard of care for this center in the performance of ESIs in 2012 differ from the standards expected of a clinic if it was called a pain management clinic?

A. Could you -- could you elaborate on that?

Q. All right. This -- some places where ESIs are performed are called pain management clinics; right?

A. Yes, sir.

Q. You-all have chosen to call yourself a surgery -- an ambulatory surgery center; right?

A. We didn't choose to call ourselves that. It is, yes.

Q. Well, that's what it is. But the name is St. Thomas Outpatient Neurosurgical Center.

A. Yes.

Q. STOPNC; right?

A. Yes, sir.

Q. This center in 2012 performed ESIs; right?

A. Yes, sir.
Q. You're aware that there were other places who performed ESIs like you-all did, but they called themselves different names; true?
A. Yes, sir.
Q. And some call themselves "pain management clinics"; right?
A. Yes, sir. They may be office space, which means they're not a surgery center, and that they don't have accreditation, so it makes it -- it's sort of -- it's a bit different.
Q. But for the performance of providing ESI care to a patient in 2012, whether it was being done at a center like yours or in a pain management clinic, the standards were the same; you agree?
A. For the procedure itself, yes.
(Exhibit 127 was marked for identification.)
Q. (By Mr. Kinnard) Now I'll hand you Exhibit 127, Doctor. This is STOPNC_629. Just read to yourself the mission first, please, Doctor.
Have you read it?
A. Yes, sir.
Q. Now, this STOPNC policy is titled "Mission and Goals." Mission -- would you read to us what it

says, please.
A. "The mission of St. Thomas Outpatient Neurosurgical Center is to provide safe, timely and effective care to the patients we serve. We strive to implement innovative, cost-effective techniques that will ensure optimal patient outcomes in pain management."
Q. Do you agree with that mission?
A. Yes, sir.
Q. Did the standard of care for this center require it to provide safe and timely and effective care to the patients it serves?
A. Yes.
Q. Is it fair that the standard of care for the center required that the center must provide safe, timely and effective care to the patients it serves?
A. Say that -- I'm sorry. Repeat the question.
MR. KINNARD: If the court reporter will read it back, please.
(The record was read by the reporter as requested.)
THE WITNESS: Yes.
Q. (By Mr. Kinnard) Okay. Doctor, you can put that down.

Doctor, did you take the Hippocratic oath?
A. Yes.
Q. First do no harm?
A. Yes.
Q. Do you agree that the standard of care for a center requires that the center not needlessly endanger its patients?
A. Yes.
Q. Do you agree that the standard of care for a center is that it must put patient safety first?
A. Yes.
Q. Do you agree that the standard of care for a center requires that it must act in the best interest of the patient?
A. Yes.
Q. Do you agree that the standard of care for the center is that it must take all steps necessary to ensure that the product being injected into the patient's spine is safe?
A. I would say that it take all reasonable steps that are part of the standard of care.
Q. So you would say that the surgery center standard of care -- strike that -- that the center standard of care is that it must take all reasonable steps to ensure that the product that is being

injected into a patient's spine is safe?
A. That are part of the standard of care. All reasonable steps that are part of the standard of care.
Q. Now, you're familiar also with the recognized standards of acceptable professional practice for an anesthesiologist caring for patients by means of epidural steroid injections in 2012, are you not?
A. I am.
Q. Those standards are national in nature, aren't they?
A. Generally. I guess there may be some regional variation, but there's a pretty consistent national standard.
(Exhibit 128 was marked for identification.)
Q. (By Mr. Kinnard) Now I'm going to pass you Exhibit 128, STOPNC_628, and ask you to look at that. Read the philosophy part, please, Doctor.
A. "St. Thomas Outpatient Neurosurgical Center will provide and facilitate care to those patients who, because of their general physical condition and the nature of the procedure to be performed, do not require acute hospitalization. Patients using this

service shall receive the same quality of care as those who are inpatients."
Q. Now, first, do you agree with that?
A. Yes.
Q. And when it says "inpatients," that means if they are in the hospital; true?
A. Yes.
Q. And so the center standard of care requires that patients at that service must receive the same quality of care as they would as if they were in a hospital?
A. Well, I'm not sure that it requires that. That's a philosophy statement. But in -- and the standard of care for a surgery center is not the same as for an inpatient facility.
Q. Well, you do agree that patients at the center should receive the same quality of care as they would if they were in a hospital. You agree with that?
A. They should have good quality care. But in -- but there are other -- other standards that apply to a hospitalized patient and the services provided at a full hospital compared to those at a surgery center.
Q. Do you agree that the standard of care for

the center includes that the center must not allow center profits to jeopardize patient safety?
A. Yes.
Q. Do you agree that the standard of care for the medical director is that he must make and keep safety of the patients as his top priority?
A. Yes.
Q. Are you familiar in general with the facility director's job?
A. Yes.
Q. And who was the facility director in 2011 and 2012?
A. Debra Schamberg.
Q. Now, why do -- why does the center have policies and procedures?
A. To provide a framework for our operations. It gives us something to refer to if we have a question about how to proceed in a given situation.
Q. And do you know if people over there are required to look through and read the policy and procedures?
A. I don't know. I don't know if the staff members when they're hired have to read the entire policy and procedure manual or just parts they might be responsible for. I don't know.

Q. Have you ever bought a home, Doctor?
A. Yes, sir.
Q. How many homes have you bought?
A. Three. Yes.
Q. Three?
A. (Witness nods head affirmatively.)
No, four, excuse me.
Q. Have you had the experience that the seller likes to brag about the quality of the home he or she wants to sell?
A. Well, I've never met the seller prior to the sale, so I don't know.
Q. Have you ever had a home inspection done of a home before you bought it?
A. Yes, sir.
Q. Why did you do that?
A. To make sure that there were no hidden problems or unrecognized problems in the -- in the home.
MR. KINNARD: We'll take a lunch break.
THE WITNESS: Okay.
VIDEOGRAPHER: This is the end of Tape No. 2. We're off the record. And the time is 11:41 a.m.

(A lunch recess was taken at 11:41 a.m. and the deposition reconvened at 12:41 p.m.)
VIDEOGRAPHER: Here begins Tape No. 3 in the deposition of John Culclasure, M.D. We're back on the record and the time is 12:41 p.m.
Q. (By Mr. Kinnard) You ready, Doctor?
A. Yes, sir.
Q. What is your understanding of what a deposition is?
A. It's a chance for you to, I guess, question me about events that you're interested in, under oath.
Q. Okay. Do you understand that a deposition is where you take an oath to tell the truth, and then one or more lawyers may ask you questions?
A. Yeah.
Q. And that at the deposition there's a court reporter?
A. And I'm sorry, I didn't --
Q. There's a court reporter like this lady at the end of the table --
A. Uh-huh (affirmative).
Q. -- taking down your answers to questions; right?

A. Yes.
Q. So you do understand what a deposition is?
A. Yes, sir.
Q. Now, earlier in your testimony, you said you had no memory of giving a deposition as an expert witness before; is that right?
A. (Witness nods head affirmatively.)
Q. True?
A. Yes, sir.
Q. You have to say yes or no.
A. Oh, yes, sir.
Q. Are you John W. Culclasure, M.D.?
A. Yes, sir. I am.
Q. Can you see that all right, Doctor?
A. Yes.
Q. This document appears to be -- it says the deposition of John W. Culclasure, M.D. Is that you?
A. Yes, sir.
Q. Taken on December 12, 2012. Do you see that?
A. Yes, sir.
Q. And in the First Circuit Court of Davidson County Tennessee -- and there's the style of the case up there. Humphrey versus Mack Wilson Griffith, M.D. Do you see that?

A. Yes, sir.
Q. It looks like a malpractice case, doesn't it?
A. Yes, sir.
Q. Do you remember now serving as an expert witness in that case?
A. Yes, sir. I remember reviewing that. I didn't remember whether we did a deposition or not, so...
Q. There's a stipulation on the Page 4 that the deposition of John W. Culclasure was taken by the plaintiff at the law offices of Miller & Martin. Do you see that?
A. Yes, sir.
Q. This ring a bell now?
A. I don't remember the questions or the exact -- the deposition. But I -- I certainly reviewed the case. I know Dr. Wilson -- I mean Dr. Griffith.
Q. Well --
A. I remember the details of the case.
Q. The question is not whether you remember the questions. It's whether you remember giving the deposition. Do you remember it?
A. I remember now. It's just -- yes, sir. I

remember.
Q. Mr. Beveridge is my law partner. And one of the first questions he asked you is "Have you given a deposition before?" What did you say?
A. 20 or so, 25 maybe. Mostly workers' compensation.
Q. But you said fewer for malpractice cases.
A. Yes, sir. I don't remember how many I've done for malpractice. Most of the ones that -- excuse me -- most of the time when I served as an expert for the case, they don't -- they generally didn't go to even a deposition, I don't think. I don't remember doing a lot of depositions for malpractice cases.
Q. The point is, you've testified in more than one medical malpractice deposition, haven't you?
A. I mean, I see this one. I don't know how many, sir.
Q. But you did do it; right?
A. Yes, sir. I guess so.
Q. Now, is there something wrong with your memory?
A. Not generally, no.
Q. Okay. Let's talk --
MR. KINNARD: Let's shut this Elmo down. Thank you.

Q. (By Mr. Kinnard) About how many total ESIs have you done in your career?
A. A rough guess would be probably be 40,000, somewhere around that. Just based on the average number and the number of years I've been doing it.
Q. Before this catastrophe we've referred to in the first couple of minutes of your testimony happened, did you ever have a patient develop arachnoiditis as a result of your injecting epidural steroid injection steroids into the patient?
A. Not that I'm aware of.
Q. Since the catastrophe happened, have any of your patients that you injected epidural steroids into developed arachnoiditis?
A. I don't know.
Q. You don't know of any?
A. Correct.
Q. Whatever steroid products you used before 2011, you were satisfied and content that they were safe; is that true?
A. Yes, sir.
Q. After the catastrophe occurred, whatever steroid product you used for epidural steroid injections, you are content and satisfied with as being safe; true?

A. Yes. True.
Q. What were you using before you switched to a product made by NECC?
A. Methylprednisolone acetate.
Q. MPA? Can we -- MPA?
A. Yes. We can call it MPA.
Q. Okay. Did it have preservative in it?
A. Yes, sir.
Q. What was the preservative?
A. Picolinium.
Q. And what is that?
A. I couldn't tell you exactly, but it's used as a preservative in some injectable medications.
Q. But to your knowledge, none of your patients that you used that with ever developed arachnoiditis; is that right?
A. Correct.
Q. After the catastrophe --
A. Well, none developed it as a result of that injection, as far as I know. There are other causes of arachnoiditis.
Q. Yeah. But not connected to the ESI?
A. Correct.
Q. After the catastrophe, what did you use for the steroid?

A. Methylpredni -- MPA.
Q. Manufactured by whom?
A. Pfizer.
Q. Did Pfizer manufacture the steroid you used before the catastrophe?
A. I believe they did.
Q. Were you able to get all the steroids you needed after the catastrophe?
A. Yes, I believe we have been.
Q. Now, somebody came to you at some point in time and said, We're having some trouble with the supplier of our MPA. True?
A. Yes.
Q. Was that person Ms. Schamberg?
A. No.
Q. Who was it?
A. I think it was either Cindy McLendon or Sandra Littleton.
Q. What is Cindy's last name?
A. McLendon, M-C-L-E-N-D-O-N --
Q. Or?
A. Sandra or Sandy Littleton.
Q. Do you know which one it was?
A. No, sir, I don't. It was just mentioned -- I think -- I think both of them may have ordered

medications for us at different times. But one or both of them informed me that we were running low on that medication.
Q. Did they tell you why?
A. Not that I remember, other than it was back ordered.
Q. What does "back ordered" mean?
A. It means they put in the order and there's none available, and they'll fill the order as soon as they get more -- more in.
Q. Did you ever have to not do an ESI because of a short shortage of MPA shortage?
A. No.
Q. In other words, you always had enough MPA to perform the ESIs?
A. Yes, but we came down to I think a one- or two-day supply a couple of times.
Q. But you never ran out? With no --
A. With no -- correct. With no guarantee of when the next order might be shipped.
Q. So was that your first knowledge by Ms. McLendon or Ms. Littleton about some sort of issue?
A. I believe so, yes.
Q. What did you tell them to do?
A. I don't remember specifically. I probably

asked them if there were other sources that we could get it from.
Q. Probably or do you remember?
A. I don't remember that specifically. This would have been a conversation when I'm -- when I probably left a patient room after talking to them and counseling them for the procedure. And they would have just stopped me as I was headed to the procedure room to take care of another patient, and just say, you know, Dr. Culclasure, we're running really low on the steroid and we're having trouble getting it. And so it would not have been a sit-down meeting, it just would have been mentioned to me in passing.
Q. What did you do as a result of that conversation in the hallway?
A. I probably either -- well, asked them to -- or if they knew why or was there a way around that, could we -- is there a way to procure the medication? I probably went to Debra Schamberg and just asked her what our options were.
Q. I'm not fussing with you, Doctor. I want to know, though, the difference between what you remember and what your memory tells you, and what think you probably would have done. Do you understand there's a difference?

A. I certainly do.
Q. Okay. What do you remember -- what do you actually remember telling either Ms. McLendon or Ms. Littleton?
A. I don't remember anything verbatim.
Q. But in your mind, as a result of one of those people or both of them talking to you, what were you thinking at the time? Do you remember that?
A. I was thinking that I didn't want to run out of the supply of that medication.
Q. And how short was this picture that they painted for you?
A. I thought that -- I think they said a few days or one to two days' supply. I thought that we got down to that low on a couple of occasions where we were about to run out.
Q. But you don't remember whether it was one or two days or a few days?
A. That's right. It just didn't -- that was not a big distinction at that point.
Q. And then what happened, according to your memory, next?
A. I don't remember how many times we got close. But I discussed the situation with Debra Schamberg and she said that she had met a

representative from a company called NECC at the FASCA meeting that she attended.
Q. At a what meeting?
A. The Freestanding Ambulatory Surgery Center Association. I think that may not be exactly it, but something along those lines.
Q. And?
A. And so she asked if it was worthwhile to check with them and see if they could supply the medication. I said that would be fine. Check with them and see what they can do.
Q. Anything else about that conversation?
A. I don't know whether at that same time or later that day or the next day, she told me that she had seen them at that meeting for at least two years, maybe that was all. But they had been there -- she had seen them there exhibiting for a couple of times, that they supplied all kinds of medications including steroid. And she thought they might be an answer to our -- our threatened supply shortage.
Q. Anything else you remember about -- up to this point in time, about speaking with anybody about this issue?
A. I never spoke to anyone from NECC. The only people I discussed this with would have been

staff, probably, as I said, Cindy or Sandy and then Debra.
Q. Are the only people you would have talked with about this supply of steroids been Cindy, Sandy and Debra?
A. Yes, sir.
Q. It's true you never talked to anybody else about this situation at that point?
A. I think to the best of my recollection that's true. It wasn't a -- it wasn't a crisis. It wasn't something that stood out dramatically. It was just something to deal with in the course of taking care of the patients.
Q. Is there anything else about these conversations up to this point in time you haven't told us about yet? Anything?
A. Well, somewhere in the sequence, Debra showed me some of the information from NECC. I don't know whether that was the first time I talked to her about it or when she told me that she thought about reaching out to them. But she did have some -- I don't remember whether it was a folder or whether it was a one-page -- I mean a one-sheet on back and front, but it just -- it was some advertising material from NECC. So I saw that at some point during the

process.
Q. Were you leaving it up to Debra Schamberg to decide where to purchase these steroids?
A. She -- it was, I guess, more of a collaboration. She just asked me if I thought that was reasonable, and I said, Yeah that's very reasonable, that they -- it looks like they do everything correctly. They've got -- they follow, you know -- it looks like they maintain high standards, everything looks like it's state of the art. So I said, That's fine.
Q. Was this in the hallway also?
A. It could have been in her office. Probably in her office.
Q. Now, did she ever let you know anything about price?
A. I think -- you know, she may have mentioned some things about price. That just wasn't something that concerned me, so I didn't really -- I didn't care whether it was 50 cents more or less or a dollar more or less. That wasn't a large sum of money. I mean if we're talking about four or five hundred vials a month, a dollar a vial wasn't going to -- it wasn't a huge change in whether the center made money or not.
Q. Well, what if it had been $3 more? Would

that have made a difference to you?
A. Well, I don't know what the cut-off point would have been. It wasn't -- that's not my issue. I'm not the -- I'm not managing the surgery center.
Q. Well, do you know whether the patient would have had to pay more -- if the switch occurred in steroids, that a few dollars more were charged to the center; do you know that?
A. That wouldn't change anything that the patient -- anything in the patient's bill. So no.
Q. But what it would change is the profit of the center?
A. Yes, it would.
Q. And we've already established that the standard of care for a center is to never let profit take priority over patient safety; true?
A. True. And it never did.
Q. Are you telling us and the jury that money had nothing to do with this decision, Doctor?
A. I said that profit did not affect the patient care.
Q. Did money have anything to do with the decision to switch?
A. Not with my decision, no.
Q. Did it have anything to do with the

center's decision to switch?
A. The center was just looking for a reliable, safe source of the medication. And I think Debra as part of her job tried to negotiate the best price -- which is what her job would require of her.
Q. Do you know what supplier was supplying the MPA to you-all before this catastrophe occurred?
A. No, sir.
Q. You don't really care about that, do you?
A. I don't care what wholesaler sends the medication over.
Q. Did you have a discussion with Ms. Schamberg, Find me steroid that's preservative-free?
A. I don't think we -- I think it was more that she said, One other advantage for NECC is they provide preservative-free steroid. We weren't actually -- we weren't actively searching for a preservative-free steroid at that time. It's always desirable -- it's desirable to have a preservative-free formulation if we're going to inject it into the spine. But it's very hard to get that for a lot of the medications. So that wasn't what really drove the decision to go with NECC. But the fact that they offered preservative-free I thought was a bonus.
Q. Have you ever used a steroid for ESI, other

than NECC, that was preservative-free?
A. I don't know. I think there might have been a betamethasone formulation that was preservative-free, but I just don't remember exactly. I didn't use betamethasone routinely, so -- or ever, really, probably.
Q. But the MPA that you're familiar with does have a preservative in it?
A. Yes.
Q. Right?
And that's what -- how many thousands of injections of that MPA, which has a -- of the preservative in it have you done?
A. Well, probably close to 40,000. It would be -- I use that almost -- I use the MPA almost all the time.
Q. If Cindy, Sandy and Debra had never had a conversation with you about some potential shortage of MPA and there had not been any sort of shortage of MPA, you would have kept on using it, wouldn't you?
MR. GIDEON: Object to the form.
THE WITNESS: Yes. If I had -- as long as the -- it was supplied to us, then I would have continued to use it.
Q. (By Mr. Kinnard) In other words, as long

as you could have gotten MPA like you were getting it from Pfizer, you would have kept using it?
A. Yes.
MR. GIDEON: Objection.
Q. (By Mr. Kinnard) I want to be certain about some things in respect to what you did about this switch to NECC. Is it true you never called a pharmacist about this potential switch?
A. Yes, that's true.
Q. Is it true you never consulted with any doctors in your group?
A. Yes, that's true.
Q. Is it true, other than some brochures that Ms. Schamberg showed you from NECC, that that's the only documents you ever saw about this proposed switch?
A. Yes, that's true.
Q. You never went to a computer and Googled NECC, did you?
A. I never Googled the name of any manufacturer or supplier that we got supplies from.
Q. The question is did you ever go to a computer and Google anything about NECC?
A. No, sir.
Q. Other than these three ladies you told us

about, did you ever talk to anybody about NECC before the catastrophe?
A. No, sir.
Q. How much trouble would it have been, Doctor, to consult with a qualified pharmacist about the question of whether what NECC does is safe?
A. I don't know.
Q. Is there anything in writing about the decision that was made to switch to NECC?
A. If there is something in writing, it would be from Debra, since she was doing the ordering or initiating the contact. I would not have made any notes that I'm aware of.
Q. If it there were any questions about the quality of steroids at NECC, did you expect Ms. Schamberg to find that out?
A. No, I expected the FDA and the Tennessee department of pharmacy and the Massachusetts Board of Pharmacy to be on top of that.
Q. Did you know, when Ms. Schamberg talked to you, that NECC was a compounding pharmacy?
A. Yes, sir.
Q. What did you know a compounding pharmacy was?
A. Compounding pharmacies take raw material

and package it for an injectable drug in a sterile form.
Q. Did you know whether or not it was FDA-regulated?
A. I did not.
Q. Did you assume it was?
A. I did.
Q. That was a mistake, wasn't it?
A. I don't know.
The FDA did go in in early 2013 and inspect and shut down some compounding pharmacies. So that makes it appear that they did have the power to do that at that time.
Q. Do you know why?
A. I don't know it offhand, but I remember seeing some news reports about that.
Q. Do you know the difference between a compounding pharmacy and a manufacturer of drugs?
A. I -- not exactly.
Q. Do you know what triggers FDA involvement when a compounder starts manufacturing drugs?
A. I don't.
Q. Did you ever go to the Framingham facility?
A. No, sir.
Q. Never been.

Did you call any doctors or colleagues and ask them, Do you use NECC?
A. No, sir.
Q. Do I understand that what Ms. Schamberg --
MR. GIDEON: Schamberg.
Q. (By Mr. Kinnard) -- showed you from NECC was their sales promotional materials?
A. I believe that's correct.
Q. Did it ever cross your mind to ask whether this compounder was -- that their drugs were FDA-approved or not?
A. No, it did not. I didn't know that a drug could be sold in the United States and not be FDA-approved.
Q. Anything else you want to add to that?
A. I think that's sufficient.
Q. Okay. Saint Thomas Health Services was a 50-percent owner of this center; is that right?
A. I've never seen the documents about that, but I think that's true.
Q. Assume it is, that according to the documents they've supplied, they're 50-percent owner; okay?
A. Yes.
Q. You did know that they had an ownership

interest, didn't you?
A. Yes.
Q. You could have called a Saint Thomas Hospital pharmacist and asked for some help if you thought you needed it?
A. Yes.
Q. Tell us every step, Doctor, that you haven't mentioned already, to perform due diligence to ensure that NECC was a safe supplier of these steroids.
A. Those were all the steps.
Q. There's nothing else, is there?
A. No, sir.
Q. Did anybody ever come to you and say, Doctor, we're getting the steroids from NECC, and now they want a patient-specific prescription? Did anybody ever do that?
A. No.
Q. Did you ever learn, before the catastrophe, that NECC wanted from the center, patient-specific prescriptions, by name?
A. No. They never asked for a prescriptions, that I'm aware of.
Q. Did they ever want a list of names of patients before they would supply the steroids?

A. Yes, they did.
Q. Were you aware of that?
A. Yes.
Q. How did you become aware of that?
A. Debra Schamberg informed me.
Q. When did she tell you?
A. I don't remember.
Q. What did she tell you?
A. That NECC wanted a list of patients because the -- they told her that it was a requirement from the Massachusetts Board of Pharmacy.
Q. What did you tell her?
A. I said that was fine. See what they need and supply them with the information.
Q. What did you think was going to be supplied to NECC?
A. Debra and I discussed it. She was concerned about relaying too much information about the patients. And so I think she negotiated with them a little bit about what they needed. So I think they got basically just a list of patient names.
Q. Okay. We're using words that worry me a little bit, "think." I want to know your memory, Doctor. Let's start over. So what did she tell you NECC wanted?

A. Well, sir, that's the best I can do. These were events that at the time were not -- were not that dramatic or unusual, and so I don't remember the day of the week or the time of the day or anything like that. I don't remember the month.
So she just stopped me while -- you know, at work or got my attention, and just said, Now they want patient names. And she was concerned about protected health information. So I just said, Find out what they need and, you know, we can -- if they're a supplier then we can provide them with that kind of information, if necessary.
Q. Did you understand that they wanted the names of patients who were to receive these injections?
A. I don't know. There was some -- Debra informed them that we wouldn't know at the time the list was sent, which ones got which medications. You know because they were -- other people used different steroids. Not every patient got MPA. And so -- but they were satisfied with having the list that way. I just -- I assumed that it meant that if for some reason something came up or the Massachusetts Board of Pharmacy wanted information from them, they could always backtrack from that list and see who got what.

They could call us and we could look up the patient and tell them, Ms. Smith got MPA and Mrs. Jones got betamethasone.
Q. So the list, as far as you thought, was not designed to tell NECC who is going to get epidural steroid product, but any product from NECC?
A. I'm -- I don't --
Q. You're going to have to explain, please, for all of us, what you mean, about the list of the patients' names could be for what?
A. I'm not understanding your question exactly. But almost all the patients got epidural steroid injections, so...
Q. Is it your understanding that each patient's name that went to NECC was injected with something later?
A. Yes, or they wouldn't have been a patient at the center.
Q. And the something they were injected with, may not have been an epidural steroid, but something else?
A. It could have been, yes.
(Exhibit 131 was marked for identification.)
Q. (By Mr. Kinnard) Let me hand you what we

marked as Exhibit 131. It's a collective exhibit, STOPNC_696. What is this, Doctor?
A. It's the policy, the title is Ethical Business Behavior.
Q. Part of STOPNC's policy manual?
A. Yes, it appears so.
Q. Looking at Page 3, do you see Principle One, Legal Compliance?
A. Yes.
Q. Would you read that for us all, please, Doctor.
A. "STOPNC is committed to conduct its activities in compliance with applicable laws and regulations. The following standards are meant to guide employees in compliance. These standards do not completely cover all applicable laws and regulations. Regardless, employees are expected to comply with all applicable laws, regulations and guidelines, use good judgment, and consult with their supervisor."
Q. You agree with that?
A. Yes.
Q. Now, look at Page 4, please, Principle Two, Business Practices. Read that first paragraph, please.
A. "STOPNC is committed to the highest

standards of business ethics and integrity. Employees are charged with representing STOPNC accurately and honestly, refraining from any activity intended to defraud anyone of money, property or services, and at all times act in good faith and in the best interest of STOPNC."

Q. Do you agree with that?

A. Yes, sir.

Q. And will you please read the next paragraph.

A. "The following standards provide guidance to help ensure STOPNC's business activities reflect high standards of business ethics and integrity. Employee conduct not specifically addressed by these standards must still be consistent with this principle. Questions regarding the interpretation or application of this principle should be directed to the supervisor."

Q. You agree with that?

A. Yes.

Q. Then the Page 10 -- you on Page 10?

A. I'm on Page 5.

Q. Well go to 10, please, sir. Read the second question, and then the answer, please.

A. "Who is responsible for understanding and

complying with the laws and regulations that apply to my work area? All employees are responsible for complying with laws and regulations as well as STOPNC policies and procedures that relate to their jobs and apply to their respective work areas. Familiarize yourself with this document for expectations regarding your business conduct. If you have questions, ask your supervisor for clarification."

Q. You agree with that, don't you?

A. Yes, sir.

Q. Did Ms. Schamberg ever come to you and say to you, I need to put the name Mickey Mouse on this document that lists the patients to NECC?

A. No.

Q. You didn't know anything about the use of Mickey Mouse's name to NECC, did you?

A. No.

Q. If she had come to you and said, Doctor, I want to use the name Mickey Mouse on this list of patients with NECC, would you have told her, Don't do that?

A. I would have asked her to redact that from the document, because there's no patient named Mickey Mouse. That's a placeholder that we would use to let the staff upstairs know that I was going to be

downstairs at a certain time on the 8th floor, after seeing a patient downstairs. So they would -- the system, to my understanding, doesn't allow a placeholder. So they would just use Mickey Mouse or Minnie Mouse, I think, as a -- as placeholders. Those names are clearly not real people, and so it just let's the staff know that -- not to book something in that slot because I was going to be elsewhere.

I think they also used those -- attached to those names are a full set of made-up demographics in the system, and when new employees come on board they train -- they learn how to put data in, do charges and things like that, using Mickey Mouse and Minnie Mouse, because those are clearly not real patients, whereas Joe Smith or John Doe could be a real patient.

Q. Have you finished?

A. Yes, sir.

Q. That is an internal arrangement the center has?

A. Yes.

Q. It's not -- the use of Mickey Mouse is not intended to go out of the center, is it?

A. No. It wasn't intended to.

Q. Do you know why she used the name Mickey Mouse?

A. I have no idea. I think that was set up long before I came. But it was explained to me that it was chosen partly because everyone would know that that was not a real patient.

Q. You mean NECC would know it was not a real --

A. No, no, no. That other employees at the -- at STOPNC would know that -- it was -- if that showed up, they knew not to book something in that slot at the center, because I was going to be elsewhere. I would be maybe downstairs on the 8th floor seeing a consult, would be the most common reason. So otherwise I would -- I could get double-booked.

The -- because the office -- the scheduling system is different for the center and for the practice. And so the -- so it would have been possible for someone to book me to see a consult as part of me being -- me being a part of Howell Allen Clinic on the 8th floor, and at the same time the center staff could have booked me to do injections on the 9th floor.

And so by having those filler names in, it was apparent to the center staff that I was not going to be there, not to book anyone in those slots.

They tended to be the first slots after

lunch, because I would eat lunch and then go downstairs and see consults, if I had consults to see downstairs.
Q. But that was never intended to communicate with NECC or anybody like NECC?
A. Correct. Those were just placeholder names.
Q. Did Ms. Schamberg tell you that the Board of Pharmacy in Massachusetts wanted NECC to get a list of names of patients?
A. No, sir.
Q. Do you get a flu shot each year?
A. I have for the last several.
Q. Do you know how much a flu shot is?
A. I have no idea.
Q. Do you have good insurance?
A. I have --
Q. Health insurance?
A. Yes, sir.
Q. Where do you get your flu shot?
A. Debra administers it to center staff.
Q. Well, if you didn't have that advantage, Doctor, and you were like the rest of us who have to go to places sometimes like Walgreens, to get a -- you ever get a flu shot at Walgreens?

A. No, sir.
Q. You don't have any idea how much a flu shot cost at Walgreens, do you?
A. Not at all.
Q. Well, if you went to Walgreens to get your flu shot, and they said, You're going to have to copay $10 instead of $5, would you do it?
A. Yes.
MR. KINNARD: Okay. We'll take a five- to seven-minute break.
VIDEOGRAPHER: This is the end of Tape No. 3. We're off the record. The time is 1:25 p.m.
(A recess was taken.)
VIDEOGRAPHER: Here begins Tape No. 4 to the videotaped deposition of John Culclasure. We're back on the record and the time is 1:40 p.m.
Q. (By Mr. Kinnard) Ready, Doctor?
A. Yes, sir.
Q. Other than with NECC, which asked Ms. Schamberg to send a list of patient names, was there ever any other manufacturer or provider of steroids that asked for such a list?
A. No, sir.

(Exhibit 135 was marked for identification.)
Q. (By Mr. Kinnard) Doctor, we've marked as Exhibit 135, STOPNC 65, 59, 58, 57, 56, as this exhibit. Do you see down here where it says physician name, signature? Do you see that, Doctor?
A. Yes. Yes. Yes.
Q. Is that your signature?
A. No, sir.
Q. Who signed your name there?
MR. GIDEON: Object to the form.
THE WITNESS: I don't know.
Q. (By Mr. Kinnard) You don't know who signed your name?
A. Well, that doesn't look like --
MR. GIDEON: Object to the form.
THE WITNESS: That doesn't look like an attempt at a signature. It looks like they were putting my name down as requested by the form.
Q. (By Mr. Kinnard) Oh, did you write your name there?
A. No, sir. I didn't. But it's -- I'm saying it doesn't look like someone tried to fake my signature.

Q. What did you say?
A. It looks like someone printed my name. It says -- the form says "physician's name/signature." So I would assume that meant the first thing to do would be to write the physician's name out, and then a signature. And that looks like my name written out, not a signature.
Q. So you never signed this, obviously?
A. No, sir.
Q. All right. Do you know what the shelf life for MPA manufactured by Pfizer was?
A. No, sir.
Q. All right. Did the procedure that you told us about, when you went in to meet with the patient for the first time, who is going to undergo an ESI, change any when you were using this product from NECC?
A. No, sir.
Q. I'm going to put up on the Elmo now, STOPNC 2386, which is Exhibit 39 from Ms. Schamberg's testimony at her deposition. Please read that, Doctor.
A. "Do I have to use certain vendors for ordering? I would like to do some price comparison with other vendors other than Cardinal. I'm not pleased with our Cardinal rep, and I know there are

some hungry vendors that would love our business. Also, I have Solar Tinting coming next week to frost the two windows looking into the ORs. Cost will be $175."

Q. Have you ever seen this document?

A. No, that -- if I did, it would have been just looking through materials that I was provided to review. But, I mean, that was hundreds of pages. I don't remember that specifically.

Q. Okay. You're talking about after litigation started in this matter, somebody sent you documents to look at?

A. Yes, sir.

Q. Who sent you the document?

A. My attorneys.

Q. I'm going to put up there now on the Elmo, STOPNC 2472, 2473 and 2474. This is from you to Debra Schamberg on July 26, 2012; right? Apparently you sent her this letter you got; is that right?

A. Yes, sir.

Q. Now, do you remember getting this letter?

A. Yes, sir. We were concerned about the -- about the contrast. The contrast came in very large vials and I don't remember now how many, 50 cc vials, and we were only using two or three ccs from each one.

It just seemed awfully wasteful, and plus we were dumping them back into the environment if we threw them away immediately. So we wanted to -- and so we had been using them multiple times on the same day, cleaning each one -- cleaning in between times and never it with -- only entering it with new needles.

And so there -- and then that became controversial and the organization ASIP, which is up there, next to Dr. Manchikanti's name, they were concerned about that too, and they thought there should be a way for practices to split up the contrast into smaller aliquots or have a compounding pharmacy do it under a sterile hood and then ship it.

And so that was why I sent that to her.

Q. Well, here's the doctor's name. Do you recognize that name now?

A. Yes, sir.

Q. Do you know him?

A. Yes, sir. I've met him.

Q. How do you say his name?

A. Manchikanti.

Q. All right. He says, "Thus even if a compounding pharmacy, which we consider not to be very safe, revised it, it would be doable" -- excuse me, "double or triple the price we would be paying when we

used a single dose vial on multiple patients."

Now, what did you take it to mean he was saying, "Thus even if a compounding pharmacy which we consider to be not very safe." What does he mean?

A. That didn't really concern me at the time. I wasn't -- that was not my focus about the letter. It was the fact that he was supporting our position that we should have some alternative to wasting so much contrast on multiple patients.

My experience by that time with NECC had been a year of being a client of theirs with no problems with their medication. So that -- my experience was not that. And over the years, we've used compounding pharmacies to make pump medications, to compound pump medications for patients that have implanted pumps. And those are complicated mixtures of drugs and they only come from compounding pharmacies.

So -- and throughout that time, with many, many years of using compounding pharmacies, I'd never had a problem with a compounding pharmacy. So my experience -- because of that experience I was not very concerned about his -- that one line in that letter. And that wasn't the focus of the letter. The focus of the letter was about having CMS allow us to

split the vials of contrast.

Q. Here's a memo from -- excuse me, an e-mail from Debra Schamberg to Bobbi Doty. Who is Bobbi Doty?

A. She's a clerical person in the practice. She's my secretary and she schedules procedures for me.

Q. Dated 12/9/2010. Ms. Schamberg said, "We may start ordering from Clint Pharma. They are local and I think they will give us better $$." What do you interpret that to mean?

A. I assume that's just her shorthand for a better price.

Q. I'm going to show you now STOPNC 4231, an e-mail. What does it mean, "from John W. Culclasure, Doctor, to John Culclasure, Senior." What does that mean?

A. She -- let me see. That means I forwarded that from my work e-mail to my personal e-mail.

Q. Okay. Why did you do that?

A. I'm not sure. Let me...

Q. Let's see what this said. Maybe it'll help you.

A. To ASA 13. Oh, that's the other guys that came in, and that was in October. I guess I must have

been -- I don't know, I guess I was obviously out of town. Sometimes -- usually what I save is when she sends me just, like, totals of what we've done, I usually save that in a folder on my personal e-mail. But I'm not sure why I saved that.

Q. Well, she told you, "We have an increase of 50 procedures over the last year." Right?

A. Yeah. But that doesn't seem worth saving. So I just don't remember why I would have saved that.

Q. She says "You have done 37 more procedures to ASA 13." What does that mean?

A. That's the group's -- the abbreviation of the group's name for the guys who came over to help me. Dr. Dickerson, Carrero, Arney, Rome.

Q. They were all combined?

A. Yes, they were all within that group.

Q. And who is Dr. A she gave a flu shot to?

A. That would be Dr. Arney.

Q. And is there any sort of animosity with her or him? Is it a woman or man?

A. It's a man. He was a very nice man. He passed away because of multiple myeloma and we were all very close to him, so there was no animosity.

Q. Now, when was the first time -- strike that.

Before somebody told you there's a possible connection to ESIs performed in the center during that summer before, were you getting any sense of there are more patients returning to Howell Allen with problems after the ESIs than usual?

A. No, sir.

Q. Nobody at Howell Allen alerted you to, "Hey we're getting more people in here for more tests after ESIs," anything like that?

A. No, sir.

Q. So you -- you were oblivious to any problem with the ESIs until somebody told you something; is that right?

A. I was unaware of any problems with the ESIs until I was informed that there was a patient at Vanderbilt who had a fungal meningitis.

Q. Who told you that?

A. I think I got a call from Debra, who'd gotten a call from the infection control nurse at Saint Thomas.

Q. Did you know the patient?

A. I didn't know him. I had done his injections. I don't think he was -- he was not a -- someone that I had seen for years like some of the patients.

Q. What was the date of that information?

A. It was September 18th. My dad's birthday is the 19th, so that's why I remember that.

Q. And what did you do about that information?

A. Debra told me -- Debra called me. I was already home and she told me that Candace wanted to know if a -- just said there was a patient at Vanderbilt who was sick and he had been diagnosed with an Aspergillus meningitis and wanted to know if he had received injections at STOPNC. And I asked her if she wanted me to go back in and find out then and she said, no, it's not -- that's not urgent. Candace just wanted to know tomorrow if he had been a patient.

So when I went in the next day to the imaging center where I am on Wednesdays, I pulled up his information and he -- there was a telephone note in the chart. He told -- he was calling to let Dr. McCombs know that he was doing better after his injections, but that he had been diagnosed at Vanderbilt with Rocky Mountain spotted fever meningitis . And -- but since that note was made, he had been re-admitted and they made the diagnosis of Aspergillus meningitis.

So I guess I contacted both -- I think I probably just talked to Debra. I don't know if I

called Candace at that point, but I told her what I saw in the record and I said, you know, I don't see how this could come from us. If someone had -- if we had had a contaminated injection, I would expect it to be, one, bacterial, and, two, an abscess, not a meningitis because that's what would happen after an epidural injection.

And so I said this seems very unusual, and I said apparently they diagnosed him with Rocky Mountain spotted fever, I said, and he had a spinal tap in July at Vanderbilt. And I said, you know, that's when the new residents and interns are there. It almost seems more likely to me that they could have, you know, con -- gotten -- you know, broken sterile technique and in the process of doing the spinal tap, they could have maybe gotten -- you know, put some aspergillus spores into him and maybe that's how this happened. But I was -- that was -- the possibility of a fungal meningitis occurring so long after this man's procedures, it just -- at that point it seemed like the more likely explanation was something else. But I reported that back. And so -- and so that's what happened on the 19th.

Q. And then what happened next as far as you're concerned?

A. I went in to work on Thursday sometime in the morning. We were -- Candace got in touch and said there might be two more patients in the hospital who have -- who have symptoms of meningitis. And so we checked to see what -- see if they had been patients at the center and they had.

I think at that point, I asked Cindy to call our suppliers and see if any of them had had any reports of unusual infections following use of their supplies or medication. I think she -- I think she called -- got in touch with GE because they supplied the contrast. We called the people who put the trays together. We called NECC so -- to try to see if anything -- if they had any reports of anything unusual, and they all said no.

But -- but so that afternoon, after sort of digesting all of this even though it just -- I could not in my mind connect the dots, I called Scott Butler, the practice manager, and I told him that I didn't know what was going on, that there were three patients who had appeared to have meningitis, and I thought that we should close the center until we knew what was going on.

Q. Would you like to take a break?

A. I'm all right. Let's go.

Q. All right. Then what happened?

A. We -- I told the staff that they needed to call the patients and just -- and tell them that, you know, we -- that we had an equipment problem that we were having to reschedule their cases for the next day. I think also that -- no, on Friday morning, I think Dr. Latham, the infectious disease specialist at Saint Thomas West, came up to -- and Candace, they came up and sort of walked around, they looked at the facility. And the Department of Health may have gotten some people out that Friday too.

From that point on, we really just became an arm of the Tennessee Department of Health. We just -- you know, they came in and told us what they needed, what we should do. And so from that point on we were basically, you know, just following their instructions on everything. I had no experience with anything like this, and so we just did whatever they said. Dr. Marion Kainer was involved. She's an epidemiologist. So she thought that if we went through the records and got lots of patient demographic data when they had their injections, what they were injected with, that we should be able to figure out what was going on.

So for a -- for quite a while we had no

diagnosis. But for -- but every day, we would get, you know -- there would be two or three more people being admitted to the hospital. And at one point Dr. Latham even thought that it wasn't infectious. That instead it was -- might have been a chemical contaminant in some of the stuff because he gave some of the patients steroids and they got better temporarily, but then they all got worse about 24 to 36 hours later.

And so that -- that next week it was -- Debra set up a process to try to call all the patients. At first they just wanted to ask -- they being the department of health -- they just wanted to us ask the patients if they were -- how they were doing and if they had any unusual symptoms, and if they did, then we were going to -- we were going to instruct them to come back to Saint Thomas and be evaluated. We did not mention the word meningitis because the department of health told us not to.

Apparently they had an outbreak of meningococcal meningitis at MTSU sometime prior to that and before they got that assessed and under control word got out, I think I was told on Twitter or something about men -- meningococcal meningitis at MTSU. That's very infectious and it tends to infect

young people, college age, people in the military living in close quarters. And so that got out ahead of them being prepared to deal with it. So they didn't want the word meningitis mentioned until they knew it really was meningitis.

So we weren't even clear on the diagnosis for probably for another week after that. One patient instead of developing meningitis had an abscess, and Dr. Standard opened her up to clean it out and then that was the first time we had tissue and it was -- I talked to the pathologist and he said it was -- it looked like fungus. It was black. And so then they tested it and it came back Exserohilum, which is not the same fungus that the first patient was growing. In fact, I think he was the only patient who ever grew Aspergillus.

I'm sorry. I don't remember the question. I probably --

Q. What we're going to do is take a break. I'm going to take -- just a brief five-minute break. We'll pick up right there when we come back; all right?

A. (Witness nods head affirmatively.)

VIDEOGRAPHER: We're off the record. The time is 2:06 p.m.

(A recess was taken.)
VIDEOGRAPHER: We're back on the record and the time is 2:17 p.m.
Q. (By Mr. Kinnard) You ready, Doctor?
A. Yes, sir.
Q. Okay. You want to continue the answer that you were giving us?
A. Could you repeat the question. I want to make sure whether I --
MR. KINNARD: What was the last subject matter he was talking about? Give us a hint of the last few lines.
THE WITNESS: And I'd also like to hear the question.
MR. GIDEON: I think the question was, "And then what happened?"
THE WITNESS: Oh, okay.
(The record was read by the reporter as requested.)
THE WITNESS: Yeah. Prior to the biopsy of the abscess, we -- everybody thought it was Aspergillus because of the first patient who went to Vanderbilt. And so they -- the infectious disease guy sent off a special -- sent off CSF, cerebral

spinal fluid, for a special test. I'm blanking on the name of it. But anyway, it's an antigen test that should be positive if the patient is infected with Aspergillus.
So we all just thought that it would confirm that the patients in the hospital had Aspergillus, and that came back negative. So then that was -- that was very confusing because then we had really no idea what was going on. We didn't know, well, maybe -- maybe what the patients had that are at Saint Thomas have is different from what Mr. R. had at Vanderbilt. And so it wasn't until Dr. Standard got the biopsy that we were able to actually get a diagnosis.
The problem -- and for a lot of the patients the problem of the -- of it being a fungal infection was that the fungal medications are hard on people, particularly older folks. It's hard on their livers and kidneys and so that made treating them -- for the infectious disease guy, that made it very difficult for them

to treat these infections for a lot of the folks because they would have problems with the medication that they needed to take.
So I think I've sort of run out of anything else to say at this point.
Q. (By Mr. Kinnard) What was the date that you started doing ESI injections again?
A. I think November 1st. I remember seeing that on a document. Oh, that's when the center opened back up, I think November 1st. I did some ESIs at the imaging center.
Q. And that was where, the imaging center?
A. Yes, sir.
Q. Where was that located?
A. On Ellison Place near Saint Thomas Midtown.
Q. A Howell Allen facility; right?
A. Yes.
Q. Or --
A. Not a facility, but owned by Howell Allen.
Q. Okay. STOPNC 2718 is an e-mail from you to Scott Butler. Would you please read the first paragraph.
A. "Debra and I talked yesterday evening. We're going to have the staff write down everything they remember. Debra and I will do the same. We will

create memorandum and sign and date it. In the future we can refer to this statement, not rely on our memory a year from now."
Q. Okay. Do you know if that was done?
A. I didn't because I think about that time we started compiling everything from all the notes that the staff had made and we put all of the information on patient phone calls and everything into an Excel spreadsheet. And so I think -- so once that started -- once that was done, that sort of had all the -- all that kind of information.
Q. Well, what happened to the notes, do you know?
A. I didn't maybe -- I don't know. I mean, I didn't make -- I didn't make a separate note myself. But initially when the staff was calling people, they would -- I think they printed out the logs from each day and they would call the patients and make -- just write next to each name, you know, patient answered, doing okay, no answer, call back, just notes like that so they would know what to do.
Q. So have you seen any of those document s in preparation for your deposition today?
A. I have not seen the spreadsheet information, no.

Q. Have you seen any of the notes, any handwritten notes or anything like that?
A. I saw them while they were -- I mean, I saw them at that time. I've not seen them in any of the materials I've reviewed for the deposition.
Q. Do you know if they were kept or destroyed?
A. I don't know. I would be surprised if Debra -- anything would be destroyed. She's pretty careful about documents.
(Exhibit 136 was marked for identification.)
Q. (By Mr. Kinnard) I'm going to mark as Exhibit 136 STOPNC_1597, which is a two-page document. It also includes 1594. It's dated October 3rd, 2012. You familiar with this letter?
A. Yes, I believe so. I think I saw it.
Q. Is this a competitor of STOPNC?
A. He has another pain practice in town. I -- I don't usually think of it as a competitor. We're closed. I mean, I'm not -- he's not -- so I don't compete with him for patients. I mean, we're a closed center. We don't take outside referrals.
Q. Okay. There's a sentence in the first paragraph where he says, "The medications utilized by the physicians at Center for Spine, Joint and

Neuromuscular Rehabilitation are FDA approved medications from manufacturers and not" -- not being in all caps -- "from compounding pharmacies."
Did you see that sentence at the time?
A. I believe I did, yes.
Q. Now, as a result of -- did you see this letter at or about the time he sent it?
A. Yes. I think -- I don't really -- I think he might have come -- come to us because we were probably on the mailing list, or came to me.
Q. Were you upset seeing this?
A. Yeah, I was upset.
Q. Were you angry about it?
A. Possibly. Yeah, because that was -- at that point things were still -- we still didn't really even know -- I imagine by then we had the biopsy diagnosis, but, yeah, yeah, I was angry.
Q. Why were you angry?
A. It just made it sound like we had done something wrong.
Q. Okay. And what did you do about that letter?
A. I think I showed it to Debra probably.
Q. Did you show it or send it to any of the members of Howell Allen?

A. I may have. I don't remember. It sounds like I -- I might have forwarded it -- could have forwarded it to Scott to let him know that this was going around.
Q. Do you know whether Scott Butler took some action about the letter?
A. I don't know.
Q. Did you ever call this gentleman who sent the letter?
A. I don't think so. Don't remember.
(Exhibit 137 was marked for identification.)
Q. (By Mr. Kinnard) Exhibit 51 to Ms. Schamberg's deposition we've marked as Exhibit 137 here, and I want to show you a copy of that. Do you recognize this?
A. I don't think so.
Q. Are you saying you've never seen this before?
A. I don't remember seeing a lot of things from Clint so I don't know.
Q. Clint makes the representation in this, "All products distributed by Clint Pharmaceuticals are FDA approved and are not implicated in this outbreak. FDA approved corticosteroids have been and are still

readily available through Clint Pharmaceuticals."
Now, do you agree or disagree with that statement?
A. That FDA approved corticosteroids have been and are still readily available through Clint Pharmaceuticals?
Q. Right.
A. If they say that they were, then I guess they had a supply.
Q. So you can't say this is incorrect; right?
A. If they had it on their shelves, I guess that's accurate.
Q. Before this catastrophe occurred, you did not know how many states NECC was licensed in, did you?
A. It's hard to say when Debra told me, you know, what about NECC some of those kind of details. I thought she told me early on in the process that they were licensed in every state in the country when we started to order from them, but, I mean, that wasn't -- that -- I couldn't put a date on that or even a rough time, but I thought that that was mentioned to me early on.
Q. Well, you didn't mention that when I asked you to tell us everything Ms. Schamberg told you

before y'all placed the orders.
A. Well, that's true. I can't think of a long list of things always, but I gave you the best answer I could at the time.
Q. Well, did you know before switching to NECC anything about whether hospitals used NECC?
A. I don't know when I became aware of that. Probably more after this occurred -- after the outbreak occurred.
Q. People told you things about NECC after the catastrophe; correct?
A. Yes.
Q. People fed you information about NECC, what it did, who all used it; correct?
A. I guess -- yes. They -- I got other information provided to me about NECC.
Q. Where did you get that information?
A. Probably mainly from Debra.
Q. Anybody else?
A. I don't remember. Most of the discussions about NECC were from Debra because she had a contact with the company and I didn't.
Q. You also did not tell us earlier when I asked you about your conversation with Ms. Schamberg that an NECC rep had told her that Vanderbilt was an

NECC customer. You didn't tell us that part. Did she tell you that before the switch?
A. I don't remember.
Q. Likely after?
A. I don't remember.
(Exhibit 138 was marked for identification.)
Q. (By Mr. Kinnard) We've marked as Exhibit 138 STOPNC_4565. What does this appear to be, Doctor?
A. Okay. I'm sorry, what was the question about the document?
Q. What is this?
A. This looks like a letter from our business manager to -- well, I'm replying to her. She must have -- she sent it to me and then I wrote back saying thanks.
Q. This is dated 10/17/2012; right?
A. Yes.
Q. You were aware of the catastrophe by then?
A. Yes.
Q. And she's -- please read the fourth full paragraph that she sent you.
A. The one that starts off with --
Q. "When you have."

A. Oh. "When you have a patient stating they will not pay for care rendered at STOPNC during the affected time period, make sure you kindly advise them of their responsibility. I will seek direction from Mr. Butler regarding how to handle these accounts and future appointments if patients elect not to pay. I would assume standard collection protocol would be followed, but I will keep you abreast of the decision as soon as I speak with Mr. Butler."
Q. Now, what's standard collection protocol? What is that?
A. I don't know. I don't work in the billing office.
Q. Were you aware that the center would sue patients for money?
A. I know that this probably came because either the patients -- the patients were complaining or I reached out to Shreka just asking if we could not charge them considering what all happened. So it could have been either one of those things. But we also -- and, I mean, I'm not a business person, but it is my understanding that with the insurance company we were not able to waive a fee or, I mean, it was a contractual obligation to, you know, balance bill the patient for their part of the service and stuff like

that. It's considered an illegal inducement if we waive the copay or the deductible.
Q. Here's another e-mail dated 10/4/2012. Do you recognize this now?
A. Yeah, I see it.
Q. Okay. You sent it to Greg Lanford and copied several people; right?
A. Yes, looks like it.
Q. Who is bholt@babc.com?
A. I have no idea. It could have also been a list of people who -- I wouldn't have had Dr. Batchelor's e-mail or Dr. Latham's. It's probably people that I had an e-mail that included those and I thought -- and I probably just copied them because I thought they all should have seen that. But I don't know who bholt is.
Q. Did you author, that is, type this e-mail where it starts saying, "We started using NECC"?
A. It's sent through my iPhone, so yes.
Q. Were these statements true when you made them?
A. Yes.
Q. Down below, there's an e-mail from somebody named Rebecca Cline. You see that?
A. Yes.

Q. Who is she?
A. She's at St. Thomas.
Q. What does she do?
A. You know, right now, I couldn't tell you.
Q. The title there says chief communications and marketing officer. Do you see that? You can't see that?
A. Oh, okay.
Q. Does that help you identify who she is?
A. Yes. Okay.
Q. Okay. Would you read to us, please, the sentence she wrote, "We are starting to get."
A. Sure. "We are starting to get inquiries regarding the use of materials from the NECC and from compounding pharmacies in general. Given that hospitals don't use compounding pharmacies, this is going to be best answered by a representative from the center. They're going to ask why centers use compounding pharmacies" -- something -- "previous problems." I can't see the rest.
Q. Well --
A. "That have -- pharmacies that have -- there have been previous problems," et cetera.
Q. Did you know whether or not hospitals used compounding pharmacies?

A. I don't think I did at the time know one way or the other.
(Exhibit 139 was marked for identification.)
Q. (By Mr. Kinnard) I'm going to mark that e-mail we just discussed as Exhibit 139, STOPNC-4422. Here's an e-mail from you to Debra Schamberg, copying Scott Butler, 11/21/2012.
MR. SCHRAMEK: If there aren't copies of the exhibits, could you read out the Bates number.
MR. KINNARD: I'm sorry. Yes. STOPNC_3097. I'm sorry.
MR. SCHRAMEK: Okay.
Q. (By Mr. Kinnard) In that -- down here, you say, "I do not want to be responsible for ordering the imaging studies and having to follow up on those." What do you mean by that?
A. If I ordered the tests, then it's my responsibility to the patient to then make sure I get the results and then get in touch with them about those results. At that point, there was so much going on, I didn't have the --
Q. You want the date?
A. I see. It's the 12th of November -- 21st

of November. But that was not what -- I was not their primary care physician. I'm not an infectious disease specialist. And so that was just me saying that the most efficient way for them to get studies done and make sure that they got proper followup was to have it done with the emergency room or with -- with their own physician.
Q. We're going to mark Exhibit 140 STOPNC_0775. It's a photograph. What would this appear to be a photograph of?
(Exhibit 140 was marked for identification.)
THE WITNESS: Depo-Medrol.
Q. (By Mr. Kinnard) Do you know when this photograph was made?
A. No, sir.
Q. I see an expiration date of 05/2013. Do you see that?
A. Yes.
Q. Is it fair to assume that that was the expiration date for this product?
A. I assume so given that the only information I have is the picture again.
Q. When this catastrophe occurred -- excuse me -- before the switch to NECC, do you know if this

drug was around, Depo-Medrol?
A. It's been around for years.
Q. Did you have it on your premises at the center?
A. I have no idea.
Q. Have you ever been sued before, Doctor?
A. Once.
Q. Was it dismissed?
A. Yes.
Q. You didn't go to trial?
A. No, sir.
Q. Are you married now?
A. Yes, sir.
Q. This is the second time?
A. Yes, sir.
Q. How many children do you have?
A. Three.
Q. Where do they live?
A. My oldest son lives in western North Carolina, Franklin, North Carolina. My next son lives -- well, I'm not sure where he lives. He and his wife travel all over southeast Asia. They have no kids at this point so they just travel. And my daughter lives in Seattle. She got married this summer and she's a principal at a grammar school.

Q. Now, what county and state did you get your divorce in?
A. Bexar, Texas.
Q. How do you spell Bexar?
A. B-E-X-A-R.
Q. B-E what?
A. X-A-R.
Q. Pronounced Bexar?
A. Yes, sir.
Q. Who filed for the divorce, you or your wife?
A. I don't remember. We didn't -- it wasn't -- we didn't contest it. So it was -- it was pretty amicable.
Q. These patients who developed meningitis after receiving the steroid injections were not guilty of any fault, were they?
A. No, sir.
Q. Would you inspect a vial of steroids before you injected them into the patient?
A. Not formally, but the way we do it, the x-ray person holds the vial up for me. So I check the vial for the expiration date, confirm it's the steroid that I want, and then I draw it up. So the vial is about 6 to 8 inches from my face. So I see what I'm

drawing up and then I also see the contents in the syringe. So it's -- while it's not a formal inspection process of the vial, I do clearly see the contents of the vial.
Q. Now, did you take a vacation starting about -- well, actually starting October 4th, 2012?
A. I think I went to Chicago.
Q. On October 4th?
A. I don't remember exactly.
Q. Why did you go to Chicago?
A. Just to get out of town for a little bit. It had just been a very intense time period. I wasn't being utilized for any patient care so I just went up for the weekend.
Q. How long were you gone?
A. I think just the weekend.
Q. A weekend.
A. The center wasn't open on the weekend so it wasn't really --
Q. Did you take a vacation in October of 2012 other than this weekend off?
A. I don't -- I don't remember.
Q. But you wanted to get out of town?
A. Yes, sir.
Q. Did you call any patients while you were up

there in Chicago?
A. I don't remember. If I got a message from Debra or someone that a patient had a question, I could have called them, but I just don't -- I don't remember.
Q. Are your parents alive?
A. Yes, sir.
Q. Both of them are?
A. Yes, sir.
Q. Do you feel that you have an addiction gene of any type?
A. I don't know. I think there's evidence that there's a genetic component to addiction.
Q. You've probably thought about this; right?
A. Yeah.
Q. Do you think you do or not?
A. Well, the data suggests that that's -- that's possible. So I think if that's true, then -- I don't think it's proven, but I think there's strong evidence that there is that component. It's the -- like many things, it's -- the outcome is a mix of genetics and environment.
Q. What does your current wife do?
A. Well, my current wife is a husband, and he's a real estate agent.

Q. I'm sorry.
A. That's okay.
Q. I beg your pardon.
A real estate agent?
A. Yes, sir.
Q. Okay.
A. 22 years together. We got married in the fall of 2013.
MR. KINNARD: Okay, Doctor. What we're going to do is take just a quick break. You can take as long as you want. I'm not sure how long we'll be, but we're going to talk amongst ourselves --
THE WITNESS: All right.
MR. KINNARD: -- and resume. I don't think it'll be much longer.
THE WITNESS: Okay.
MR. KINNARD: Thank you.
VIDEOGRAPHER: We're off the record and the time is 2:47 p.m.
(A recess was taken.)
VIDEOGRAPHER: Back on the record and the time 3:05 p.m.
EXAMINATION
BY MR. CLAYTON:

Q. Dr. Culclasure, Daniel Clayton. I have a few questions for you.
A. Okay.
Q. You mentioned previously that you have used compounding pharmacies in the past. You recall that testimony?
A. Yes.
Q. What sort of products have you ordered from those compounding products -- compounding pharmacies?
A. Combinations of medications used to fill implanted pain pumps, those generally pump medication into the spinal canal, the spinal fluid sac, and usually those involve two and sometimes three different medications all combined into that, you know, one refill when we do it. And then -- so that's multiple drugs combined. And then a couple -- sometimes we would order alcohol, absolute alcohol when I had a neurolytic procedure to perform.
Q. Explain that for me, please. What do you mean a neurolytic procedure?
A. Alcohol destroys nerves. So there's some nerves that are amenable to destruction. Some nerves can't be destroyed because they provide motor function to an arm or a leg. But some nerves only provide sensory function, and those nerves can be destroyed

without causing a problem for the patient.
An example would be something called a celiac plexus, and it's a collection of nerves that supply sensation to the part of the abdomen. And so if someone has pancreatic cancer, I can do an injection with the absolute alcohol and destroy that collection of nerves and give them some pain relief.
Q. So had you done that type of procedure using the absolute alcohol at STOPNC?
A. Yes, I believe so. Yes. Because we had to order it -- I don't think I did it in the operating room at St. Thomas. I think it was at STOPNC.
Q. On how many different patients?
A. Probably two or three. It's not a common procedure.
Q. So how many times have you done that at STOPNC using the absolute alcohol?
A. Two or three probably. Not a lot.
Q. When was the last time you did that procedure?
A. Gee, probably at least two, three years ago.
Q. And where did you get the absolute alcohol from?
A. There's a pharmacy near Saint Thomas

Midtown. I don't remember the name of the pharmacy. I mean, I can drive you there, but I don't remember the name.
Q. Near the old Baptist --
A. Yes.
Q. -- Health and Wellness Pharmacy?
A. I think it is that, yes.
Q. Mark Binkley?
A. I don't know the name of the pharmacist.
Q. Did the -- in order to obtain the absolute alcohol, was a patient-specific prescription required?
A. I believe it was, yes.
Q. And did you sign that prescription?
A. I don't have a rec -- specific recollection, but if that was what was required, then we probably -- I probably signed it.
Q. In other words, the absolute alcohol had to be used on a patient that you were obtaining it for through the Health and Wellness Pharmacy; correct?
A. Yes.
Q. With regard to the medications used to fill the implanted pain pumps, have you done that at STOPNC?
A. No, that's done in an office setting, not in a facility.

Q. So would that be done at the Howell Allen imaging clinic where you go on Wednesdays?
A. No. It would generally be done in the office on the 8th floor below STOPNC.
Q. Did -- were any ESIs ever performed on the 8th floor?
A. No.
Q. They would not be allowed to be performed on the 8th floor; correct?
A. Well, they could be.
Q. Do you know if any physicians performed ESIs on the 8th floor?
A. Not that I'm -- none that I'm aware of.
Q. Okay. So how often would you need medications used to fill implanted pain pumps at the -- is it the Howell Allen Clinic on the 8th floor?
A. Yes.
Q. Okay.
A. There could have been -- oh, gosh. It would depend on when. But because at times we might have had a hundred -- a hundred pump patients. So there could have been six to ten to 15 pump refills on a given week. It just depends on when they're due to run out or if we -- if -- because of side effects or lack of efficacy, we would have to remix the --

rebalance the drugs that we ordered.
Q. Would each patient be different or would it be something that you could use the same on any patient?
A. Generally -- generally different. It might be the same medication but in different concentrations because a patient who had been on that a long time would have a higher tolerance and would need a higher dose. Someone who had not been on it very long would have less tolerance and would be on a lower dose.
Q. And when was the last time that you have used medications to fill implanted pain pumps?
A. Oh, gosh, probably a year and a half or two years ago. We just referred all the pain pumps out to other providers in Nashville. It was just -- it was hard for me to provide the supervision for those patients with my other duties. It's sort of a lot to keep up with. We had trouble keeping a nurse practitioner who was trained. And so some practices have four or five nurse practitioners because they're bigger and they -- and so if one nurse practitioner takes another job, then there's still others who can help do the pump refills. But if there's just one and that person leaves, then I have no one else to do that, so it would be hard for me to do that and take

care of STOPNC.
Q. Did -- or when did you start referring those patients out?
A. I don't remember exactly. One and a half to two years ago would be my best guess.
Q. Would it have been after this catastrophe happened at STOPNC?
A. I don't -- I don't remember the sequence of events.
Q. Where would you obtain the medications used to fill the implanted pain pumps?
A. That varied. And sometimes it depended on the insurance company. I think Blue Cross/Blue Shield of Tennessee designated a specific pharmacy -- compounding pharmacy in Tennessee. Other patients we would use a different -- a different place. I don't remember all the different ones that we used over time.
Q. Tell me the names of any of them that you used over time?
A. I couldn't. I don't know.
Q. Any of them out of state?
A. I don't -- I just don't know. I didn't do the actual ordering. The nurse practitioner did. So I don't know the -- I just don't know the name of the

company.
Q. Who was the nurse practitioner?
A. There were several. Keri Weber, Allison -- I'll think of her last name in a minute, but there were three or four that -- that did that for me.
Q. Did they work at the Howell Allen Clinic there on the 8th floor?
A. Yes.
Q. Do they still work at the Howell Allen Clinic?
A. No.
Q. None of the four do?
A. Correct.
Q. Do you have something that you can look at to help refresh your memory of the names of those four people?
A. Nothing handy.
Q. But back at the office you think you have it?
A. I wouldn't have a list of them.
Q. For the medications used to fill the implanted pain pumps, were those patient-specific prescriptions?
A. I think they were ordered on a different DEA form, and I don't know that they -- on that form

it includes any information about the patient. I think it's just numbering, the drugs and concentrations. So it's not actually like a prescription that we normally would give to a patient to take to a pharmacy.
Q. Was the prescription for the absolute alcohol something that you would give to the patient to take to the pharmacy?
A. No. We would probably -- probably have faxed it to the pharmacy or somebody would -- I would have had the secretary drop it by if they couldn't take it by fax. So the patient didn't pick up that drug. They -- we either then picked it up or they delivered it. I don't remember.
Q. For the medications used to fill the implanted pain pumps, then, you're saying there may have been some form that was signed that would not be patient specific?
A. I think that's correct. I haven't seen that form in a while, so I'd have look at it to refresh my memory.
Q. Would you even sign any of those forms, because nurse practitioners are allowed to sign them, aren't they?
A. I did at one time, but -- earlier in my

career when I was ordering them myself, I did fill that form out, but the nurses -- the nurse practitioners did do most of that afterwards, yes.

Q. When you said earlier in your career, would that have been at the Howell Allen Clinic or somewhere else?

A. No, somewhere else. Primarily when I was in North Carolina I know I did it myself then. And at times if somebody was on -- if the nurse practitioner was on vacation, if someone needed to be refilled early, then I would -- then I would have to order it.

Q. So are you saying while you have been practicing medicine in Tennessee that you have written orders for medications used to fill implanted pain pumps that have been sent to compounding pharmacies that were not patient-specific prescriptions?

A. I think that's the case. I'd have to see the form. It's been a long time since I filled a form out myself.

Q. I'm talking about in Tennessee whether or not you have done that.

A. Oh, I understand your question. I'm saying I just don't remember.

Q. Was there any prescription written for the compounding products that were received from NECC?

A. Not that I'm aware of, no.

Q. You saw earlier that prescription order that had your name printed or written on it, but you said that was not your signature or you had not -- you did not write your name on that.

A. Correct.

Q. Is that not considered under Tennessee law a prescription order?

A. I don't know.

MR. GIDEON: Objection.

Q. (By Mr. Clayton) You don't know?

A. I don't know if that's considered a prescription or not, no.

Q. And was that the only type of order that was used to obtain the products from NECC?

A. I don't know.

Q. Have you ever allowed anyone to sign your name to a prescription for a medication?

A. No.

Q. That would not be allowed, would it?

A. No.

Q. Did you review all of the brochures that Debra Schamberg gave you regarding NECC?

A. If she gave them to me, I -- I would have looked at them, yes.

Q. Well, what is it that you recall she gave to you?

A. I've seen some of the things -- some of the materials from NECC since that time. So I don't really -- it's a little bit hard to say what I saw at the time. I -- earlier today, I said I thought what -- one thing that I saw was a two -- a glossy two-sided sheet of paper with information on the processes that they use, the standards that they met. It could have also been a four-page foldout. I just don't remember.

Q. Your ex-wife -- what was your ex-wife's name?

A. Maiden name?

Q. Her name, please.

A. Elizabeth Penny, P-E-N-N-Y.

Q. And where does she currently live?

A. Chicago.

Q. And when were the two of you divorced?

A. Probably 1987.

Q. And are your children a result of the marriage from her?

A. Yes.

Q. You were subpoenaed to give testimony to the grand jury in Boston?

A. Yes.

Q. Did you go?

A. Yes.

Q. Did you ever invoke the Fifth Amendment?

A. Never.

Q. With regard to the fentanyl abuse, how did you account for the missing fentanyl that you stole?

A. Usually by saying that I gave two vials -- two vials instead of one. So the patient always got an adequate amount. I just -- I just wrote on the record that I gave, you know, more as if the patient had a high tolerance. So the record would balance out, but...

Q. So you would falsify patient records in order for you to cover up your fentanyl use?

A. Yes.

Q. And did you do that during both occasions whenever you were abusing the fentanyl?

A. I don't remember -- I don't remember in Johnson City whether I had access to the records there or not. So I don't know, but definitely the first time in the Army, yes.

Q. Well, if you didn't have access to the records in Johnson City, then how did you account for the missing fentanyl there?

A. Well, there was waste. And so if the nurse set the syringe down, I could pick up the syringe.
Q. Any other way?
A. No, sir, not that I remember.
Q. You had sent an e-mail asking How -- asking if Howell Allen was going to pursue a claim on your behalf for lost wages. Do you remember sending that e-mail?
A. Vaguely, yes.
Q. Okay. Tell me the reasons why you sent that e-mail.
A. I think someone told me that that was -- that that was possible. And so I just asked if that was -- if that was part of the -- if that was the plan.
Q. Who told you?
A. I don't remember.
Q. What were you told when you sent that e-mail?
A. Probably there were -- it was possible to collect damages because of lost income.
Q. I'm sorry, I did not hear what you --
A. It was possible -- someone -- I guess someone told me it was possible to collect damages because of lost income and so I guess I was just

inquiring if that was a possibility.
Q. And what was the response that you received?
A. I don't remember.
Q. Well, you're aware that -- or are you aware whether or not Howell Allen has filed a claim in the bankruptcy for its losses?
A. I'll not sure.
Q. Or lost money?
A. I don't know.
Q. Is it --
A. I'm not a partner so I don't attend business meetings and things like that. So I don't know what's been filed.
Q. Whenever these other physicians from ASA would perform the ESIs at STOPNC, if I understand correctly, Howell Allen would not pay them directly; is that correct?
A. Correct. They did their own billing.
Q. Would you receive any sort of compensation for ESIs that were performed by the ASA folks at STOPNC?
A. No.
Q. Did you receive any type of separate compensation for being the medical director of STOPNC

other than the 60 percent that you would receive from Howell Allen for performing the ESIs?
A. No.
Q. So there was no separate stipend from anybody to be the medical director?
A. Correct.
Q. Do you personally know any compounding pharmacists who live in the Nashville area?
A. Yes. First name, though. I don't remember -- his name is John.
Q. That's a -- you don't know his last name?
A. No.
Q. Do you know the name of the company he works for?
A. No.
Q. How long have you known him?
A. Three or four years.
Q. You were aware back in 2011 and 2012 that there were compounding pharmacies in Tennessee; correct?
A. Yes.
Q. And compounding pharmacists in Tennessee; correct?
A. Yes.
Q. For the fentanyl -- you're -- for your

fentanyl use, was there ever any -- or were there ever any criminal charges that were brought against you?
A. No.
Q. Were you ever threatened with any criminal charges?
A. No.
Q. Did you go straight from being a non-illegal drug user to starting to use fentanyl?
A. Yes.
Q. Had you abused any other drugs of any kind, whether they were prescription or illegal drugs, prior to using fentanyl?
A. I smoked some marijuana in college.
Q. Were any of the -- were you familiar with any of the other physicians' preference, whether they preferred using Depo-Medrol versus MPA over at STOPNC?
A. A preference between Depo-Medrol over MPA?
Q. Yes.
A. No.
Q. Or Depo-Medrol over a compounded pharmaceutical like the one that NECC provided.
A. No.
MR. CLAYTON: Short break.
VIDEOGRAPHER: This is the end of Tape No. 3. We're off the record and the

time is 3:25 p.m. I'm sorry. That was Tape No. 4.

(A recess was taken.)

VIDEOGRAPHER: Here begins Tape No. 5 in the deposition of John Culclasure, M.D. We're back on the record and the time is 3:31 p.m.

Q. (By Mr. Clayton) Dr. Culclasure, have you ever attended any CMEs regarding being a medical director?

A. No.

Q. Have you ever had any training to be a medical director?

A. No.

Q. So while you were in your treatment program in Nashville, the folks who ultimately formed the Howell Allen Clinic, one of the people there came to you and asked you to be a medical director --

MR. GIDEON: Objection.

Q. (By Mr. Clayton) -- of the pain clinic?

A. He called me and then asked me to come -- if I could come interview. So I -- yes. So that's how that happened.

Q. Is it your position as the medical director of STOPNC that STOPNC obtained the MPA from New

England Compounding Company without ever writing a prescription?

A. Would you repeat that.

Q. Is it your position as the medical director of STOPNC that STOPNC obtained the MPA from New England Compounding Center without ever writing a prescription?

A. I'm not sure if that form is considered a prescription. So if it's considered a prescription, then we submitted a prescription. If it's not a prescription, then we didn't. I can't answer the question any better than that.

Q. And if it's considered a prescription, then it's a prescription that's being submitted without your signature on it; right?

A. Yes, in that example that you showed me.

Q. And how does that comply with Tennessee law, do you know?

A. I don't know.

MR. CLAYTON: That's all I have. Thank you.

MR. GIDEON: Next. That's two for the PSC. Is there anybody else who is not with the PSC that wants to ask any questions?

MR. REHNQUIST: Go over a little bit, yes.

MR. GIDEON: Besides Jim who always has some more questions. Anybody else? Okay.

EXAMINATION

BY MR. REHNQUIST:

Q. Good afternoon, Dr. Culclasure. My name is Jim Rehnquist. I'm a lawyer for a company in this case called UniFirst. I'm just going to ask you a few followup questions.

As I recall, your first job after your relapse was with neurological associates?

A. Neurosurgical Associates.

Q. I'm sorry. Neurosurgical Associates. And you fully informed them of your substance abuse issues?

A. Yes. That was -- when the treatment center let me go interview, that was a requirement. They said the first thing I had to do is tell them I was in treatment and discuss that with them.

Q. And then you informed them of both the original incident and then your subsequent relapse?

A. I don't remember that -- exactly what we discussed in that. That was in 1999.

Q. Well, what do you remember of what you informed them about your substance abuse issues?

A. I told them -- I don't remember clearly. I probably told them -- well, I told them I was in treatment at that time, that it was -- it was -- I abused opioids. And the main thing I remember from the meeting was when -- because I was really nervous about having to tell them that because I needed to get a job after I got out.

And so I said, "So I'm an addict and I'm in treatment," and they all started laughing and one of them said, well, we're all addicts. And so they -- they just made me feel -- I don't know what he meant by that exactly because they're not all addicts, but it may have been just him trying to make me feel better or at least have their own unique issues or something. So that's the thing I remember mostly from that interview, was that they all started laughing and I was not quite sure what they were laughing about at first.

Q. Did you tell them the substance you abused was fentanyl?

A. Probably.

Q. I mean, fentanyl is used with the administration of anesthesiology; correct?

A. Correct.
Q. And you think you probably told them that or you're positive?
A. Well, I don't remember the details of the discussion. It's likely that I did since that was my drug of choice. If I told you today that I remembered specifically saying that, that would not be true because I don't.
Q. And did they put any -- did the people at Neurosurgical Associates put any sort of conditions or restrictions on your work because of the substance abuse issues?
A. I don't. The Tennessee Medical Foundation did initially, and I don't remember the -- exactly -- the exact number of hours, but they -- they make us restrict our work hours for three months or some period of time after treatment, but I think that was from the TMF, not from the practice.
Q. Did the practice put any conditions or restrictions on your work with them as you recall because of your past?
A. I don't remember any specific restrictions.
Q. Did they require you to continue going to AA and NA meetings?
A. Well, the TMF did and the board, the

Tennessee Medical Board did.
Q. And have you done that since you left treatment?
A. Yes.
Q. And I believe you testified that you left Neurosurgical Associates when that group sort of split up and you eventually ended up working at STOPNC -- I'm sorry, you ended up with the Howell Allen Clinic?
A. Yes, it was like a -- an immediate job change. It wasn't a -- it wasn't eventually. It was just a transfer.
Q. Okay.
A. So my employment date with Howell Allen actually goes back to when I joined Neurosurgical Associates because it was somehow they -- I don't know all the reasons for that, but it was as if I had been with Neuro -- with Howell Allen for the whole time.
Q. So when the -- with the name change and the change in that practice, the people you were working with after the name change and the change in the practice were the same people you had been working with before?
A. Well, Neurosurgical Associates had six members and three of them joined Howell Allen and they wanted me to come along. So then I joined -- and then

they were -- I don't remember however many there were with Howell Allen at the time, eight or nine. And so the three guys that I had worked with and I joined Howell Allen.
Q. And the -- I'm sorry.
A. So there were eight or nine guys I had not worked with before.
Q. And what steps did you take to fully inform the eight or nine members of Howell Allen that you hadn't worked with before about your substance abuse issues?
A. I don't remember. I've always been pretty open about it. It's not anything that's hidden. The board knows. I don't remember any specific document that I gave them. But it was not a -- it was not a secret, but I don't remember a formal notification process.
Q. Do you remember doing anything to inform these new members or the eight or nine that you hadn't worked with before about your past?
A. I don't remember.
Q. You were asked questions about the name STOPNC and why the name Neurosurgical is in that name even though there's no neurosurgery being performed there. Remember that question?

A. Yes.
Q. Were there any -- were there ever any discussions within Howell Allen about the disconnect between the name of STOPNC and the functions that STOPNC was performing?
A. Because I'm not a partner, if they discussed that at a business meeting, I wouldn't be aware of it.
Q. So you weren't aware -- regardless of whether they discussed it at a business meeting or otherwise, you weren't aware of any such discussions?
A. Correct.
Q. Was there ever any confusion among patients, to your knowledge, about being referred to a facility with the word "neurosurgical" in the title when they weren't getting neurosurgery?
A. I never had a patient ask me about that.
Q. Did you ever hear about a patient asking anyone at STOPNC that?
A. Not that I recall.
Q. You testified that your payment terms are that you receive 60 percent of what Howell Allen is able to collect from the procedures that you perform?
A. Yes.
Q. What happens if Howell Allen can't collect

from a procedure that you performed from an insurer or a third-party payor?
A. Then there's just no money collected for that particular procedure.
Q. If the money is collected from the patient directly, do you receive the same 60 percent of that if it's collected?
A. I would assume so. I've never had that discussion with anybody.
Q. Are you aware of any situations where any insurance or other third-party payors have not provided reimbursement to Howell Allen for an ESI procedure that you performed?
A. Not specifically. I mean, there are a lot of reasons that -- that can cause a problem. If it's -- if a procedure is approved for a certain date or a range of dates, sometimes it's just one day, some of them are really difficult, and then the patient reschedules and the staff doesn't catch that, then they won't reimburse. So if they're supposed to come in on Tuesday but we had an ice storm and they came in on Friday, then some insurance companies will not reimburse that. So...
Q. But you don't recall any issues other than those kind of administrative issues coming up?

A. That's primarily it. I mean, if they -- if the patient got scheduled and they're with a particular -- and their diagnoses didn't establish medical necessity with their insurance company, then we can do the procedure and not be reimbursed. I mean, if that's -- I generally ask the billing not to balance bill patients if there are errors that occurred because of something that we missed. If I'm aware of it, I don't want the patients billed.
Q. Do you remember any ESI patients not being reimbursed for medical necessity reasons?
A. Not specifically. I don't get a report from the business office about how many are not being reimbursed because of a problem. That's just not the data that I get.
Q. So if there were medical necessity issues that came up, you wouldn't have known about them?
A. Probably. I've asked the billing office if there is a problem, you know, to let me know if they need, you know, help with diagnosis codes or anything like that or that I can help with, but I don't know of any -- they don't -- I haven't gotten a call about any specific patients that didn't -- you know, insurance denied payment for.
Q. What entity handles the billing for STOPNC?

A. It's internal to the practice -- or Howell Allen. Excuse me. The Howell Allen billing office, I believe, handles them.
Q. A patient who's considering getting an epidural steroid injection presumably like most procedures has other options; correct?
A. Yes.
Q. What are the other options that a patient has in lieu of getting an ESI?
A. Time, analgesics, physical therapy. Those would be the main ones.
Q. Who do you mean by time?
A. Just waiting, see if it gets better.
Q. You described the sort of initial consult you -- that you do with the new patients earlier today. And I believe you said, you know, you walk into the room and the patient's got the blue wristband and they're in street clothes and you go over things with them for a few minutes, and then you might leave that room to go and do a procedure, for example.
When you walk into the room the first time to meet the new patient, what do you know about that patient as you walk into their room?
A. Well, I've already picked up the chart and I look at the chart. So I see some basic demographic

data like their age, sex. And the nurses have the nursing history filled out so I look at that. I look at allergies, make sure they're not on a blood thinner. It lists their medications. I review those. It lists medical illnesses that they've told the nurses about. It lists their surgical history. So I look through that and also their imaging. The nurses print out their last imaging reports. So I have that available too. So I'm aware of all that when I walk into the room.
Q. And when do you become aware of that with respect to the moment that you walk into the room?
A. Immediately before because I would be at the -- at the nursing station there's a rack that they put charts in that belong to patients that I have not seen yet. So I pick up the next one, open it up, look at that information that I just described and then I walk into the room.
Q. How much time do you spend looking at that information before you walk in the room?
A. It could be anywhere -- if they're young and healthy, there's very little there. It could be a couple of minutes. A lot of that is spent on the imaging probably. Because if there's nothing filled out, it's easy to scan. Not allergic to anything, no

significant past medication history, no surgeries.

If it's an older patient or a patient who has other medical illnesses, then there's more to read so that takes a little bit longer. It's hard to say. I mean, it just depends on how much I have to go over. And then I go into the room and I verify what they've got. "You're not allergic to any medicines; is that correct?"

"Yes." Because I just want to make sure that -- you know, that what the nurses have recorded is accurate, so...

Q. Now, these new patients, they are already scheduled for both the consult with you and the procedure on the same day; correct?

A. Yes. I wouldn't characterize it as a consult. It's not --

Q. How would you characterize that, that 10- or 15-minute part of that?

A. Well, consult has a specific meaning about -- that it's a separate billable event and, you know, and all that. This is just -- I just -- it's just me reviewing -- it's integral to the procedure. So there's no additional billing or anything. It's just me answering their questions, describing the procedure, counseling on the risks.

Q. Okay. And when you counsel them on the risks and verify their information and so forth, do you explain to them the other options they have instead of actually getting an ESI?

A. Yes. Well, I may say, "Well, I see from the history that you've already had physical therapy, you're taking some pain medication and this has been bothering you for three months." In that case, there really is not -- the other alternative then is just not to have it, and I always tell people you don't ever have to have this injection.

Q. Do you ever recommend to patients that they try other options or try other options for a longer period of time and not have the ESI that day?

A. Some -- sometimes. The more common reason I cancel a procedure is if -- if they come back and they're doing well, and I'll go, "Well, your pain's -- you're rating your pain as a one or two. I can't make you any better than that probably. Why don't we cancel today's procedure and you just save it until you need it down the road." So that's more common than what you described.

Q. What percentage of the time do you recommend to a new patient that they not have an ESI that day?

A. It happens but it's not real common. I'm trying to think about what those circumstances -- well, sometimes they'll come in and they've just gotten better since the surgeon made the referral and so I'll say, "Well, you know, you might stay -- you might stay good for a long time. There's no reason to do an injection since you're really doing well. Let just see how long this lasts. Maybe you won't need this."

Q. Would you say it's less than ten percent of the time?

A. Oh, yeah. Oh, yeah. It's certainly less than ten percent.

MR. GIDEON: Let him finish his question before you start to answer.

THE WITNESS: Oh, I'm sorry.

Q. (By Mr. Rehnquist) Less than five percent of the time?

A. For a new patient? Probably two to three percent as a very rough guess.

Q. Do patients ever decide, apart from a recommendation that you made, not to have an ESI that day for any reasons?

A. I'm not sure that I understand the question or how I would know if they didn't.

Q. I'm sorry. I think we just established that you might recommend a patient of your own volition not to have the ESI that day that's already been scheduled in a rough guess of two to three percent of the time; correct?

A. Yes.

Q. And are there patients that ever, even if you don't make that recommendation, decide not to go through with the ESI?

A. That would be extremely rare.

Q. It's already scheduled; right?

A. Yes.

Q. Now, with patients who are receiving a second or a third injection, have you or anyone in your office spoken to them between the first injection and the day they show up for the second injection?

A. Generally not unless it's about scheduling. But there -- they're informed by the nurses that if they're doing well they can cancel -- they should just call and cancel it and then reschedule it when they -- if and when their pain returns.

Q. They're told of that -- they're told that by the nurses when they check out of the -- from the first appointment?

A. Yes. Yes.

Q. How often -- I'm sorry -- in your experience, how long does it generally take -- after receiving an ESI of MPA or Depo-Medrol does it take for the patient to know if the first injection has worked?
A. I usually tell them that it may take anywhere from a few days to a week to see what it's going to do. I explain to them that it's a slow release preparation and so it may -- you know, not to expect a change in the first day or two, although some people will experience that.
Q. You know that Debra Schamberg had her deposition taken in this case?
A. Yes.
Q. Did you talk to her about her deposition either before or after it?
A. When she came back I asked her how it went, and she said, "I'm sorry, I can't tell you anything about my deposition."
Q. Did you talk to her about it before she went?
A. Some. Not real specific. I mean, I -- I know she met with someone to do some preparation before the -- before the deposition and she was really pleased. She said it made her feel a lot better, more

relaxed.
Q. Did you feel the same way after your preparation?
A. Yes.
Q. And did you talk to Debra Schamberg about your deposition --
A. No.
Q. -- in the couple of weeks before it?
A. No, other than just, you know, that it was coming up because she's aware of the scheduling, I had to be out today.
Q. Did you read the transcript of her deposition?
A. No.
Q. Do you know who the Saint Thomas Hospital pharmacist is or was?
A. No.
Q. Does the name Martin Kelvas mean anything to you?
A. That does -- Marty, I think. That does sound familiar, Marty Kelvas, I believe.
Q. Do you know who he is?
A. I wouldn't know him if he walked in here.
Q. Do you -- do you have a memory of how the name come up or how you became familiar with the name?

A. Probably from Debra mentioning his name, but other than that, I don't remember the context.
Q. Now, you aren't a pharmacist; correct?
A. Correct.
Q. You don't have any pharmacy expertise?
A. None.
Q. Debra Schamberg is not a pharmacist and she has no pharmacy expertise?
A. That's true.
Q. STOPNC has a pharmacy consultant named Michael O'Neil; correct?
A. Yes.
Q. And Mr. O'Neil is retained by STOPNC for the specific purpose of advising STOPNC on pharmacy matters?
A. Yes.
Q. But neither you nor Ms. Schamberg ever reached out to him regarding the initial decision to purchase NECC?
MR. GIDEON: Objection, peer-review, 68-11-272. You're instructed not answer.
MR. REHNQUIST: I think he already answered that question, C.J.
MR. GIDEON: Huh?
MR. REHNQUIST: I think he already

answered that question that he never reached out to them.
MR. GIDEON: If he did, then he just ignored what I said. Immaterial, isn't it?
Q. (By Mr. Rehnquist) Did you have any discussions with Ms. Schamberg about whether you should reach out to Michael O'Neil to ask him about the decision to purchase product from NECC?
A. No, not that I remember.
Q. Why not?
A. Why don't I remember?
Q. Why didn't you reach out to him? Why didn't you have discussions on that subject with Ms. Schamberg?
A. I've never asked for any pharmacist feedback on us purchasing, ordering medications from any supplier. It's never become -- it's never been an issue. Today it's different, but in -- in 2011 when we decided to place that order, it was not. As I said earlier, the FDA, the Department of Pharmacy in Massachusetts, the Department of Pharmacy here in Tennessee, all of those institutions are in place to protect patients and make sure that the drugs are prepared correctly. It never -- if never crossed our minds that there would be -- that these -- that this

entity NECC would not be regulated.
Q. Doctor, do you still have Exhibit 135 in your stack there?
A. I do.
Q. And you were asked about this document and I believe you said that you -- that's not your signature?
A. Correct, that's not my signature.
Q. Do you recall seeing this document or documents like this document prior to September of 2012?
A. I don't recall one way or the other. I was not involved in the ordering so I -- I wouldn't have seen it unless it just happened to be left out on the desk and I just glanced at it or something, but I don't remember -- I never filled one out. I don't remember -- I never remember signing one.
Q. Is it -- I believe your testimony was that you believe you heard about the MPA supply issues from either Cindy -- Cindy McLendon or Sandy Littleton?
A. Yes.
Q. Is it possible you might have first heard about those issues from Debra Schamberg?
A. It's possible, but to the best of my recollection, it seems like I was at work, walking by

the desk where they sit, and I think one of them told me -- that was when they would catch me because it was very informal and they just -- I think at that point they said -- because they're the ones who were ordering, so they knew the status of the orders. So I think it probably came from them rather than from Debra, but if could have. I mean, it could have come from Debra. I just don't remember.
Q. And I think you testified that the context in which you were facing this, I think, you know, one-day or two-day or a couple of days' supply, and that was it, you said that wasn't a crisis; correct?
A. I think I did use that term. It wasn't something that -- just being short was a concern, but it wasn't at that point a crisis.
Q. Well, if -- if -- if you had run out of MPA in two days, that would have been a crisis, wouldn't it have been?
A. Well, I would substitute a different steroid, but that was the one I started using in training. That's one that I prefer because of its long acting nature. So I would rather use that and that's just what I'm used to using, but, I mean, I could -- we could over the short term make altered -- change and use a different one.

Q. What other -- what other steroid options would you have considered or what other -- I'm sorry?
A. Triamcinolone, betamethasone.
Q. So if the supply of MPA had literally run out or it appeared to be on the verge of running out, you could have ordered an alternative steroid?
A. Yes, or we had some on hand because some of the other anesthesiologists who work there used other steroids.
Q. But your preferred choice was to find a source of MPA?
A. Yes.
Q. And approximately how much time elapsed between the time that you first heard about the shortage and the time that STOPNC began ordering from NECC?
A. I don't know.
Q. Less than a week?
A. No. I think it would be longer than that because it happened -- I think that they informed me of shortages or supply problems at least twice or maybe three times. So I think it was over they would tell me we're about out and we would get a shipment in. So it happened several times, so it wasn't -- it wasn't a week after the very first time we encountered

a problem.
(Exhibit 141 was marked for identification.)
Q. (By Mr. Rehnquist) Dr. Culclasure, I'm handing you a document that's marked Exhibit 141. This is STOPNC's response to plaintiff's first set of interrogatories in the case of Reed v. STOPNC. Can you just look at that.
A. Sure. The entire thing or part of it?
Q. Well, I'm going to focus you on something in a moment.
MR. GIDEON: Is there a particular question you want him to look at?
MR. REHNQUIST: Yeah.
Q. (By Mr. Rehnquist) Can you look at Page 16. Can you read the question and answer to No. 8, top of Page 16, please, Doctor.
A. Yes. "Describe each and every action St. Thomas" --
Q. I'm sorry. You can read it to yourself.
A. Oh. Okay.
Q. In the third paragraph of the response it states "Ms. Schamberg complied with the acceptable standard of professional practices for drug procurement practices by speaking to Mr. Notarianni

regarding NECC, consulting with Dr. Culclasure, and reviewing materials provided by NECC regarding the sterility of its compounded processes."

Do you see that?

A. Yes.

Q. What acceptable standard of professional practice is being referred to there?

A. Well, I don't -- I don't know that there was a -- the standard would -- at that time was to order the medication from a licensed pharmacy. So there was no -- there were no procedures in place. I've gone to CME, I mean, classes for years. I've never -- or conventions or meetings. I've never heard anyone address anything about ordering from a compounding pharmacy or any other source for that matter.

So, again, as I mentioned earlier, that's -- that's why, you know, we thought at the time that the FDA was there, why the Massachusetts Board of Pharmacy was there and why the Tennessee Board of Pharmacy was there. It was their job to ensure that the medication supply was safe.

Q. So are you now saying that there was no acceptable standard of professional practice for drug procurement at that time?

A. Well, the standard was to order the drug from a licensed pharmacy.

Q. And where is that standard -- where was that standard contained?

A. From my experience.

Q. It wasn't written down anywhere?

A. Not that I'm aware of.

Q. Is STOPNC accredited?

A. Yes.

Q. And by what body?

A. Joint Commission.

Q. And what is the significance to STOPNC of being accredited?

A. I'm not sure exactly -- I mean, probably -- well, in order to have contracts with insurance companies, I imagine that we have to show that we're certified by one -- I think there's another certifying body that also specifically credentials surgery centers. So I don't remember the name of that one, but that body and the Joint Commission both credentialed ASCs.

Q. And being accredited as a healthcare provider means that you are in compliance with the accreditation body's standards?

A. Yes.

Q. Did you at any point ask Ms. Schamberg to determine whether NECC was accredited by anybody?

A. No.

Q. This has been previously marked in this case as Exhibit 31. It's STOPNC -- begins at STOPNC_513, but it doesn't appear to be consecutive thread. It's Exhibit 31 to Schamberg.

Can you just look through Exhibit 31, Doctor, and tell me if these are -- or appear to be the materials that you received from Ms. Schamberg regarding NECC.

A. It's hard for me to say that. I remember -- I don't remember this many different pages. So I just -- I don't remember the details of the documents that I saw. But I don't think it was this many individual documents.

Q. Did you read the materials that Ms. Schamberg showed you?

A. The one that she showed me, yes.

Q. How long did you take reading it?

A. Gosh, I think it was -- as I said, it was as few as two pages and maybe as many as four. So it didn't take long to look at it. They were bullet pointed items. It wasn't like there was paragraphs to read.

Q. Can you look at document that has the Bates stamp 522. It's probably about five, six pages in.

A. The date stamp five -- STOPNC_0522? Okay.

Q. Yeah. On Bates stamp Page 522, do you see the heading GE dispensing?

A. Yes.

Q. And it said "Product is dispensed by patient-specific prescriptions only. There must be a specific practitioner/patient/pharmacist relationship to dispense to an individual patient or facility."

Do you see that?

A. Yes.

Q. Do you recall seeing that language in the materials that Ms. Schamberg showed you?

A. No.

Q. If you had seen that language in the materials Ms. Schamberg showed you, would you have done some followup?

A. If -- I don't know. I don't know.

Q. I mean, ultimately, you didn't write prescriptions for individual patients for the MPA that was ordered from NECC, did you?

A. Correct.

Q. Dr. Culclasure, you had previous experience with compounding pharmacies before you bought MPA from

NECC?
A. Yes.
Q. And were you aware of any of the published literature about risks of using compounded drugs at that time prior to ordering from NECC?
A. No.
Q. I'm showing you what's marked as Schamberg 32. It's a May 31st, 2007 FDA consumer health information publication. Do you see that?
A. Yes.
Q. And do you see at the top of the middle column on the first page, going back to the bottom line on the previous column, but "Consumers need to be aware that compounded drugs are not FDA approved, Anderson says. This means that FDA has not verified their safety and effectiveness."
Do you see that?
A. I do.
Q. And at the time you made the decision to order from NECC, you did not know that compounded drugs are not FDA approved either, did you?
A. That's correct.
Q. Would you have ordered those drugs from NECC if you had known they were not FDA approved?
A. I don't know.

Q. If you turn to the second page of this exhibit, under the heading "What can you do," in the third column on the right, the first say bullet point says, "Ask your doctor if an FDA approved drug is available and appropriate for your treatment." Do you see that?
A. I do.
Q. None of the patients that you treated were aware they were being injected with the drug from a compounding pharmacy, were they?
A. That's correct. Also on that document under enforcement on the second page, it says that "The FDA historically hasn't directed enforcement against pharmacies engaged in traditional compounding, says Anderson, rather we focus on establishments as activities raise the kinds of concerns normally associated with the drug manufacturer and whose compounding practices result in significant violations of the new drug adulteration of misbranding provisions of the Federal Food, Drug and Cosmetic Act."
So it sounds like even in 2007 the FDA was saying that a pharmacy like NECC would fall under their scrutiny.
Q. And why did you chose to add that onto your answer -- why did you choose to add that passage onto your answer?

A. Because I think it shows that even in 2000 -- that as far back as 2007, the FDA in this communication is recognizing the fact -- is telling people that they would be looking for problems with entities like NECC. She also says that the FDA recognizes that states have a central role in regulating pharmacy compounding. That's just a point that I made earlier. They were located in Massachusetts. They were inspected by the Massachusetts Board of Pharmacy and they had to get permission to sell their drugs -- their medications here in Tennessee. So that's why we have these governmental regulating bodies, to ensure the safety of our medication supply.
And so those two things right there point out -- point to the fact that, one, the FDA says that NECC was the type of facility they should be looking at, they would be looking at, and that there's also a significant state role. So both the FDA and the states fell down or didn't live up to their responsibilities in this situation.
Q. So you think this catastrophe was the government's fault?
A. I said the regulating agencies. So they're

part of the government, yes, sir.
Q. And you think -- you think it was their fault this catastrophe happened?
A. Well, I think that it could have -- it may have been preventable had they done their job with the checking on NECC.
Q. Did STOPNC do anything wrong?
A. We ordered in good faith from NECC. I don't -- at that time, I was unaware of any particular issues involving compounding pharmacies. I don't think we did anything wrong.
Q. You ordered in good faith based on a review of their self-promotional materials?
A. We didn't order -- we didn't go and purchase it from the back of a -- the trunk of a car in a dark alley.
Q. Do you think you should have done more due diligence with respect to NECC before you made the decision to purchase from them?
A. I think we did what was appropriate at the time. In ret -- now with all of this -- all of the information and lots of other compounding pharmacies having products recalled. In fact, big companies, pharmacy companies like Johnson & Johnson have frequent recalls of their medications. So now things

are different, but at that time, this issue was not on the radar of most practitioners and providers.
Q. Prior to 2012, had you ever heard of ESI patients getting fungal meningitis from an injection?
A. I think I saw one report. I don't remember when I saw that. I don't remember how the -- how the contamination occurred. I don't remember whether I saw that prior to our event or after.
Q. This has been marked as Schamberg 35.
A. Okay.
Q. I'm showing you Schamberg 35, which is a -- the CDC morbidity and mortality weekly report for December 13th, 2002. Do you see that?
A. I do.
Q. Is this the report that you were referring to?
A. I don't know.
Q. If you look at the first paragraph, it references two cases of meningitis in North Carolina. Do you see that?
A. Yes.
Q. And do you see that this refers to five cases of fungal infection associated with contaminated drugs prepared at the compounding pharmacy?
A. Yes.

Q. And you think you might have seen this at some point, but you don't recall whether it was before or after our situation?
A. I probably would not have seen the MMWR. I don't get copies of that. I don't subscribe to it. I might have -- might have seen this referred to in -- online or something after -- after the outbreak occurred with us.
Q. Do you think you might have seen it before the outbreak occurred?
A. I've never gotten copies of MMWR. I never got that prior to the outbreak.
(Exhibit 142 was marked for identification.)
Q. (By Mr. Rehnquist) This is Exhibit 62, Dr. Culclasure -- I'm sorry. No. It is --
MR. GIDEON: 142.
MR. REHNQUIST: 141?
MR. GIDEON: 142 is what the number is that you put on there.
MR. REHNQUIST: Yeah, 142.
Q. (By Mr. Rehnquist) Do you recognize Exhibit 142?
MR. GIDEON: STOPNC_352.
THE WITNESS: Yes.

MR. REHNQUIST: I'm sorry.
Q. (By Mr. Rehnquist) And what is this? This is an e-mail exchange that you're on?
A. Yes.
Q. And this is after the outbreak?
A. Yes, it appears to be.
Q. Who is Damon Dozier?
A. A pain management physician in Clarksville, Tennessee.
Q. And do you recall why you were communicating with him on this subject?
A. I got a lot of e-mails about that -- about the issue of midlevel providers doing spine injections because for several years I was the president of the Tennessee Society of Interventional Pain Physicians so a lot of people would contact me if they had issues or they wanted me to be aware of something.
Q. Lax is the Laxmaiah Manchikanti whose name came up earlier.
A. Yes.
Q. And he's a pretty big deal in this field?
A. Yes.
Q. You say in the e-mail to Mr. Dozier, Dr. Dozier in No. 2, referring to what Lax said, you said that 60 percent of ESIs are unnecessary. Do you see

that?
A. Yes.
Q. And then you add parenthetically, "That is okay for discussion among us because ESIs are abused, but I think not appropriate for discussion with the general public especially at this time."
You see that?
A. Yes.
Q. In what ways do you believe ESIs are abused?
A. A lot of providers will -- they choose patients who are inappropriate for ESIs. They always -- they require the patients to have three ESIs no matter whether they're doing better or not. I've seen images from other providers where the contrast is not in the epidural space. So there are a lot of poorly trained or untrained people or -- I don't know a lot, but there are a number who can -- they can do these injections in their office, there's no peer-review, there's no quality improvement process that's in place.
And so it was a way for them to, you know, submit charges to insurance companies and get reimbursed for these procedures when they're not being applied appropriately or correctly . And the -- I

said the discussion is good -- it's okay for discussion among us at this time, but not the general public because it was in the midst of the -- or right after the meningitis outbreak and I just didn't think it was appropriate to -- it was a different issue about what people were doing and the issue of contaminated medicine.

Q. What is the -- what were STOPNC's procedures about the number of injections that -- the number of ESI injections that a patient could receive and the time frame within which a patient could receive those injections?

A. Generally -- generally we tried to not space them any closer than two weeks. If somebody was going out of town and they said, "I'd like to get my second one in ten days," then we would probably do that. And then generally a maximum of three in a series. Three within a six-month period is my rule of thumb.

Q. And was there -- was there any kind of a spacing requirement between the second -- the second and third? Was it the same?

A. Same, ten to 14 days.

MR. REHNQUIST: I have no further questions. Thank you, Doctor.

THE WITNESS: You're welcome.

MR. GIDEON: Anyone else?

MR. CLAYTON: I have a couple followup.

FURTHER EXAMINATION

BY MR. CLAYTON:

Q. Dr. Culclasure, you mentioned a few times during your testimony about the Tennessee Department of Health, the Massachusetts Board of Pharmacy and the FDA, that you believe that they are somehow at fault for this catastrophe; is that right?

A. Yes.

Q. And explain to me how you think they are at fault.

A. They are the agencies that should have been regulating NECC.

Q. So back in 2011 and 2012 were you of the mindset that you thought that they would be the agencies that were relegating or watching over a company like NECC?

A. Yes.

Q. So when did you contact the Massachusetts Board of Pharmacy to find out whether or not they had any investigations going on regarding NECC?

A. I did not contact them because we assumed

that if they were in business, that they were good. If there was a significant problem, I assumed that the Massachusetts Board of Pharmacy or the FDA would have prevented them from selling their medications or that the Tennessee Board of Pharmacy would have stopped them from shipping medications to Tennessee.

Q. And so you mentioned the FDA. When did you contact the FDA or do any search on the FDA's website prior to purchasing from NECC to see what sort of investigations or what sort of warnings they had?

A. I didn't because as long as they were doing business, I assumed that they had clearance from the FDA.

Q. So your assumption -- you're assuming that as long as they're doing business, then they must okay with the Massachusetts Board of Health and the FDA and the Tennessee Board of Pharmacy?

A. Absolutely.

Q. In making that assumption, do you believe that that is consistent with the policies and procedures of STOPNC with regard to providing optimal care --

A. Yes.

Q. -- for its patients?

A. Yes.

Q. And providing safe care for its patients?

A. Yes.

Q. What are you-all doing now at STOPNC to make sure that companies or compounding pharmacies like NECC are okay to deal with?

A. We're not ordering from any compounding pharmacies at this time.

Q. Have you ordered from any compounding pharmacies at all after this catastrophe?

A. I don't think so.

Q. So what are you doing in order to make sure that the -- the MPA that you're ordering from a manufacturer is safe?

A. Nothing different. We're ordering from Pfizer.

Q. So the only change that STOPNC has made after this catastrophe is to stop ordering from compounding pharmacies; correct?

A. Correct.

Q. And you would agree with me that prior to 2011 and 2012, there were warnings from the FDA and warnings in the medical literature regarding the dangers of ordering from compounding pharmacies, you would agree with me, wouldn't you?

A. There were, yes.

Q. And you just didn't know about it?
A. I didn't know about it.
Q. And you think that's acceptable, being a medical director of a STOP -- of STOPNC to not know about the warnings that were out there available against ordering from compounding pharmacies?
A. I've never been instructed, I've never attended a lecture, I've not read materials that said that anything else needed to be done when you're ordering from those pharmacies at that time. It's not possible for me to review every -- everything that is put out on the Internet or -- or studies. I -- I depend on our professional societies to help with that and I depend on the regulatory agencies to ensure that the drug supply is safe.
Q. So are you blaming the professional society too along with the government for this catastrophe?
A. Well, they don't have any power to do anything about NECC.
Q. Well, are you blaming your professional society for not putting out warnings about dealing with compounding pharmacies?
A. I don't think the risk was clear then as it is now.
Q. Why do you say that?

A. Well, there's never been an outbreak to this prior to that.
Q. Have there been deaths associated with compounds pharmacies before regarding ESIs?
A. Yes, I just -- we just reviewed one document.
Q. And you weren't aware of that before --
A. No.
Q. -- y'all started ordering from NECC?
A. I was not.
Q. And you never even contacted a compounding pharmacist who was in your back yard prior to ordering from NECC, did you?
A. That's correct. I doubt that he would have had any knowledge of NECC.
Q. He would have had knowledge about the regulations regarding compounding pharmacies, wouldn't he?
A. I don't know.
Q. Didn't you see the e-mail that was sent out by the Health and Wellness Pharmacy, Dr. Mark, Binkley, shortly after this catastrophe occurred that went to your office?
A. I don't know. You'd have to show it to me.
Q. Doesn't it say specifically about

patient-specific prescriptions? You don't recall seeing that e-mail?
A. I don't know.
Q. When did you first learn about the need for patient prescription -- patient-specific prescriptions when you were ordering from a compounding pharmacy?
MR. GIDEON: Objection, form.
Q. (By Mr. Clayton) You can go ahead, Doctor.
A. Are you asking when we were told that by NECC that they needed patient names?
Q. No. I want to know when did you learn that a patient-specific prescription was necessary in order to obtain MPA from a compounding pharmacy?
MR. GIDEON: Objection.
THE WITNESS: I didn't know that until after the outbreak when -- when all -- when more information came out.
Q. (By Mr. Clayton) How far after the outbreak did you learn that?
A. I don't recall.
Q. How did you learn that?
A. When it came up in discussions. I don't remember exactly, but it was brought -- it was brought up about the -- the Board of Pharmacy and Massachusetts required patient-specific prescriptions,

but that was a requirement on NECC to obtain those. I'm not sure that it applied to me to provide them unless they asked me for those.
Q. Doesn't the Board of Pharmacy in Tennessee also require back in 2011 and 2012 patient-specific prescriptions?
MR. GIDEON: Objection.
THE WITNESS: I'm not sure.
Q. (By Mr. Clayton) Have you ever asked anybody about that?
A. I don't think so.
Q. Would you agree with me that the name Mickey Mouse was used to obtain MPA from NECC?
A. No.
Q. Have you not seen that list that went to NECC in order to obtain MPA?
A. That was a clerical error on the part of a clerical person who copied that log sheet and sent it in.
Q. They sent it in to NECC; correct?
A. Yes.
Q. So the name Mickey Mouse was used in order to obtain MPA from NECC; correct?
A. If they didn't understand that that was an error, then I guess it could have, yes.

Q. So that was an error on STOPNC's part for submitting that name along with the names of other patients who may or may not even be receiving the MPA. Is that what you're saying?

A. I said those were placeholder names and should not have been included in what was sent out.

Q. Were patients -- do you feel like patients of STOPNC were looking to STOPNC to make sure that whatever is being injected into their spine was safe?

A. I'm sorry, would you repeat that.

Q. Do you think the patients of STOPNC were looking to STOPNC to make sure that the -- whatever was being injected into their spine was safe?

A. Yes, just like I expected that what NECC was providing me was safe.

MR. CLAYTON: That's all I have. Thank you.

MR. GIDEON: Anybody else? Hearing none, that's it. We will read and sign.

VIDEOGRAPHER: This concludes the deposition. This is the end of Tape No. 5. We're off the record and the time is 4:31 p.m.

(Deposition concluded at 4:31 p.m.)

DISCLOSURE

Pursuant to Article 10.B of the Rules and Regulations of the Board of Court Reporting of the Judicial Council of Georgia which states: "Each court reporter shall tender a disclosure form at the time of the taking of the deposition stating the arrangements made for the reporting services of the certified court reporter, by the certified court reporter, the court reporter's employer or the referral source for the deposition, with any party to the litigation, counsel to the parties, or other entity. Such form shall be attached to the deposition transcript," I make the following disclosure:

I am a Georgia Certified Court Reporter. I am here as a representative of Discovery Litigation Services, LLC. Discovery Litigation Services, LLC was contacted to provide court reporting services for the deposition. Discovery Litigation Services, LLC will not be taking this deposition under any contract that is prohibited by O.C.G.A. 9-11-28(c).

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Blanche J. Dugas
CCR No. B-2290

STATE OF GEORGIA:
COUNTY OF FULTON:

I hereby certify that the foregoing transcript was reported, as stated in the caption, and the questions and answers thereto were reduced to typewriting under my direction; that the foregoing pages represent a true, complete, and correct transcript of the evidence given upon said hearing, and I further certify that I am not of kin or counsel to the parties in the case; am not in the employ of counsel for any of said parties; nor am I in any way interested in the result of said case.

March 31, 2015

BLANCHE J. DUGAS, CCR-B-2290

CAPTION

The Deposition of JOHN W. CULCLASURE, M.D., taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

It was agreed by and between counsel and the parties that the Deponent will read and sign the transcript of said deposition.

DEPOSITION ERRATA SHEET

DLS Assignment No. 21012

Case Caption: In Re: New England Compounding Pharmacy, Inc. Products Liability Litigation

Witness: JOHN W. CULCLASURE, M.D. - 03/23/2015

DECLARATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury that I have read the entire transcript of my deposition taken in the captioned matter or the same has been read to me, and The same is true and accurate, save and except for changes and/or corrections, if any, as indicated by me on the DEPOSITION ERRATA SHEET hereof, with the understanding that I offer these changes as if still under oath.

Signed on the _____ day of

_____, 20___.

_____

JOHN W. CULCLASURE, M.D.

CERTIFICATE

STATE OF GEORGIA

COUNTY OF FULTON

Before me, this day, personally appeared, JOHN W. CULCLASURE, M.D., who, being duly sworn, states that the foregoing transcript of his deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.

_____

JOHN W. CULCLASURE, M.D.

SUBSCRIBED and SWORN to before me this _____day of_____, 20___ in the jurisdiction aforesaid.

_____ _____

My Commission Expires Notary Public

If no changes need to be made on the following two pages, place a check here ____, and return only this signed page.

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JOHN W. CULCLASURE, M.D.

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JOHN W. CULCLASURE, M.D.